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COMMON LESIONS OF THE CERVIX*

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The rare things in medicine are neither the most interesting nor the most important. The insignificant cold may lead to dangerous pneumonia and the trivial ulcer often terminates as a carcinoma. No better example of the importance of minor conditions can be found than in the common everyday garden variety cervical lesions. As a forerunner of serious pelvic disease they stand in uncontested first place. Recognition of this fact by physicians in general would deal a powerful blow to disease of the female pelvis—*a preventive measure of the highest order.*

Conservationists recognize the importance of prevention in reducing timber loss from fire. Prevention is fundamental, it is basic. Fire fighting apparatus which can be quickly mobilized to any part of the timber lands is available for putting out fires before they are well started. Prevention is also said to play an important part in modern medicine, yet in the field of gynecology it appears to be little more than a pipe dream. The vast number of women treated for menorrhagia, metrorrhagia, backache, pelvic pain, etc., etc., with never a pelvic examination, is ample proof of this contention.

Many physicians hold that the cervix is a much abused organ. That it is the object of considerable meddlesome interference by physicians in general, and gynecologists in particular. Those who lean to this view are likely to overlook significant precursors of serious pelvic disease. Theirs is the error of omission rather than commission. True, many physicians subject every cervix to careful scrutiny. With colposcope and microscope they regard its peculiarities. Their enthusiasm may bring the patient added expense and minor discomforts, but theirs are errors of commission and seldom of serious import.

There is no mystery concerning the common lesions of the cervix. A familiar sight to every practicing physician, most of them need no lengthy description. However, since the aim of this paper is to bring out the potentialities of these lesions, a clear understanding of their nature is essential. Interpolation of the following descriptions may, therefore, be looked upon as a brief review, necessary for a better understanding of this paper.

Erosion of the Cervix.—The term erosion comes near being a misnomer. Only for a brief period does the term actually describe the lesion of the cervix which carries this appellation. Actually a so-called erosion of the cervix is a reddened area around the external cervical os, somewhat irregular in outline and produced by columnar epithelium of the type lining the cervical canal. Whether this replacement of squamous by columnar epithelium is the result of metaplasia, spread from ectopic glands, or downward extension of columnar

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epithelium from the canal proper is not definitely known. Significant as a predisposing factor is chronic irritation, most likely from infection. Apparently the columnar epithelium is better able to withstand irritation (chemical and bacterial, or both) resulting from infections of the cervical canal and as a consequence, is often called upon to spread its protective membrane beyond its normal boundaries. This substitution or replacement of squamous by columnar cells is preceded by sloughing or loss of squamous epithelium from the immediate vicinity of the external os. At this stage of development an "erosion" of the cervix may truthfully be said to exist. Loss of normal flat epithelium, however, lasts but a short time, for it is soon replaced by the tall columnar cells which characterize the lesion. During its stay the columnar epithelium, true to form, lays down new glands where normally glands do not exist. Removal of the predisposing irritation leads to healing, squamous epithelium pushing its way back to force away the ectopic columnar cells. Doubtless this replacement process, which occurs in both directions, is largely dependent on environment favorable to one or the other cell type. Healing, however, seldom obliterates entirely all evidence of preëxisting erosion, once the columnar epithelium has become deeply rooted. The new formed aberrant glands remain to be disposed of. This is sometimes accomplished by down growth of squamous epithelium into the glands, while, in other instances, the returning epithelium merely bridges over the gland duct. In the former we find buried epithelial plugs and in the latter case aberrant glands without openings are seen. Possible significance of these changes will be pointed out later.

Erosions of the cervix are also said to be congenital. No doubt they occur but it must not be forgotten that erosions found in children or young unmarried women can also be explained on the basis of preëxisting genital tract infection. This need not be specific—indeed it appears that erosions are more often associated with non-gonorrheal types of cervical gland infection.

Eversion.—Eversion or ectropion occurs secondarily to lacerations of the cervix and, as the name implies, means a rolling out of the lining mucous membrane. Unless associated with an erosion it may readily be distinguished from the latter by its localization to the central portions of both anterior and posterior cervical lips. The difference between an erosion and eversion is significant. It is the difference between aberrant and normally located epithelium and glands, and the difference in etiology.

Cystic Change.—Cystic change of the cervix is also secondary in origin. Its occurrence, subsequent to an erosion, may be readily understood when we recall that normally there are no glands in the vaginal surface of the cervix. New aberrant glands are formed in this region, however, in the development of an erosion. Healing results in the new glands being filled with flat epithelial cells or the gland ducts may be bridged by squamous epithelium resulting in dilatation of the occluded gland. Small as these glands are, they may become markedly distended with their own mucus, reaching the size of a pea or marble.

Chronic inflammation of the cervix may be responsible for cystic change deeper in the cervical tissues. The edema and connective tissue changes, which are part of an inflammatory process, cause narrowing or compression of the gland lumen, resulting in distention to the point of cyst formation. These cysts, also spoken of as Nabothian cysts, appear as one or more "sago seed" bodies buried under the cervical epithelium. Puncture of their thin covering results in discharge of the clear mucous content. Like all aberrant tissues these dilated or cystic glands may be precursors of other more serious diseases.

Cervicitis.—Cervicitis implies a more general involvement of the cervix in contradistinction to infection localized only in the cervical canal. The term endocervicitis, or infection of the glands lining the canal, though useful and descriptive of acute infections, is not adequate for the vast majority of cervical infections. Starting as a localized process in the compound branched glands of the cervical canal the inflammatory reaction rapidly spreads to involve the deeper structure of the cervix. This must be fully comprehended to realize the extent of involvement and potential damage resulting from cervicitis. Changes induced by chronic long standing infections are well known. Increased fibrosis and loss of normal vascularity are common results. Loss of elasticity and normal responsiveness to

the forces of labor is only one of the many difficulties caused by the insignificant appearing changes in the cervix.

Cervical Lacerations. — Description of these common lesions is unnecessary. Except for hemorrhage in extensive tears there are no symptoms caused directly by the acute tear. Similarly old cervical tears seldom cause symptoms directly. More often the laying open of the cervix associated with constant exposure to infection, leads to such subsequent changes as scarring with cicatrix formation, hypertrophy, infection, inflammation, which in turn causes untoward symptoms. Being such a potent contributory factor in causing other diseased conditions of the cervix their repair is generally indicated in the more extensive cases.

These, then, are the common lesions of the cervix. They are seen by physicians every day. And that, precisely, is the theme of this paper. Too frequently the physician sees only the cervix. He fails to recognize that an erosion of the cervix is not just misplaced epithelium. It is more than that. Similarly cervicitis is more than just an infection of the cervix. *If "prevention" in gynecology is to be more than a pipe dream then these common lesions of the cervix must be reëvaluated* and from several points of view. Every cervical lesion should be weighed in the light of the following possibilities:

1. *As a precancerous lesion.*—Carcinoma of the generative tract is the most common form of cancer in the female and cervical cancer heads the list. We do not yet know which, if any, of the several lesions discussed is the true forerunner of cervical cancer, yet there exist certain facts which are too well established to be overlooked in this connection. Thus it is generally accepted that *cancer does not begin in healthy tissue,* that it is *always local in its incipiency,* and that *there is a precancerous stage* even though the particular lesion cannot, as yet, be named. If these things be true, and we believe they are, then there can be no good reason why every common lesion of the cervix should not be viewed with suspicion and treated until cured. Only by recognizing these facts and by seeing to it that every patient who consults us has or is made to have a healthy cervix, can we really hope to make headway in the prevention of cervical cancer. No valid argument exists that will justify the old attitude of watchful neglect. The simple yet adequate remedial measures available for treating these conditions no longer justify indecision or therapeutic vacillation.

2. *As a focus of infection.*—Perhaps the case against the infected cervix as a focus of infection is not yet so impressive. Yet, until the problem has been definitely settled, every infected cervix should be looked upon as potentially just as important a focus of infection as any other accepted focus in the body. Why should an active infection in one part of the body—in a tooth let us say —be a serious menace to health, and yet an active cervical infection be harmless? Sound logic will not permit our accepting such a fantastic view. There are many very good reasons why the cervix cannot be overlooked in search for foci. Histologically it is ideally constructed for just such purpose. The compound branched glands, abundant blood supply and generous lymph drainage well justify what Sturmdorf nicked, the "tonsil of the pelvis." Anatomically it is constantly exposed to infection in the form of vaginal flora. In adult, married women this means a wide variety of organisms including many pathogenic varieties. The extensive lymph drainage back into the sacral, iliac and inguinal glands permits ready access to the deeper tissues of the body, including the parametria.

The mere fact that, in the past, treatment of cervical infections appears to have resulted in little improvement in individuals with disease of infectious origin, means nothing. Why should it? Older methods of treatment characterized chiefly by surface applications of one antiseptic or another could scarcely be expected to affect the deep-seated focus in the branched cervical glands. Where treatment has been more radical, cause and effect relationship has been shown to exist. Perhaps the infected tonsil would be considered another innocuous focus playing no part in systemic disease if all we did was to paint it with some mild antiseptic. Even though conclusive proof is lacking there is abundant reason to believe the infected cervix plays quite as important a rôle in systemic disease of infectious origin as does any other body focus. Every diseased cervix should be evaluated from this point of view.

3. *As a cause of local symptomatology.*—The common lesions of the cervix are frequently associated with abnormal vaginal discharge, but leukorrhea is not the only local symptom. Itching, burning, frequency, bearing down sensations, dysmenorrhea are others which must be added to the list. Persistent unexplained low backache may be due to extension of infection from the cervical glands. Similarly dysparunia is not infrequently associated with cervical infection and secondary spread to the loose areolar parametrial tissues. Local symptoms associated with these common lesions may not be serious, but like the common head cold they cause untold annoyance and much genuine suffering.

4. *As a cause of sterility.*—Sterility is no problem to the average physician. For the average lay person sterility might prove a welcome change from the usual worry of pregnancy. To unfortunate women who cannot conceive, however, sterility is much more than an annoying incident. It is a serious affair of far reaching consequences. Study of this problem requires care and perseverance. Causes are numerous, not least significant of which are diseases of the cervix, particularly cervicitis. The gross evidence seen on inspection may appear insignificant, yet the thick tenacious mucopurulent discharge in the cervical canal proves an impenetrable barrier to the sperm. Excessive scarring and stenosis of the cervix also contribute to the causation of sterility. While the general practitioner seldom encounters sterility as a problem he nevertheless has a big responsibility in its prevention. To him falls the responsibility of curing disease of the cervix in its early stages, before permanent changes occur, some of which contribute to sterility later in life.

5. *As a cause of dystocia.*—The relationship between common cervical lesions and prolonged labor is seldom mentioned, yet in the presence of extensive tearing with cicatrix formation the cause and effect relationship is obvious. Less apparent, but quite as rational, is the slow dilatation of the cervix seen in primipara due to long standing low grade infection with associated fibrosis of the cervix. Not only does the excessive connective tissue proliferation called out by the inflammatory process reduce normal elasticity of the cervix and prevent satisfactory dilatation but it also predisposes to more frequent and deeper tears.

Just how important cervical infections may be in sepsis following confinement remains to be seen, but it can be safely stated that, given a choice, no physician cares to see his patient come to term with active infection of the cervix. Pathogenic organisms have been isolated from cervical cultures. The potential dangers from this source warrant treatment, even during pregnancy.

Treatment. — Detailed consideration of the many adequate methods of treatment is not a function of this paper. Improvements over earlier methods are numerous. Whereas our predecessors had to choose between local application of antiseptics or surgery, the physician of today may choose from a presentable list the method of treatment most suitable. In so doing he can also assure his patient of better and more direct treatment with much less inconvenience and discomfort. Today many cervical lesions can be cleared up with two or three simple office treatments with the actual cautery with vast saving in time and effort for both patient and doctor. The more extensive lesions formerly requiring radical and often difficult surgery may now be treated just as effectively without prolonged hospitalization.

Attitude concerning common cervical lesions has changed. In its evaluation the careful examiner sees more than just an erosion, eversion, laceration, etc., as the case may be. *He envisions disease of tomorrow, located in the cervix and forecast by the often insignificant looking disorder before him.* With remedial measures no longer a problem, the thinking physician, mindful of the responsibility which is his, cannot fail to bring to his patient every ounce of prevention which is justly hers. Failure to do so means fumbling a great opportunity for prevention of disease in the female pelvis.

SANITARY CONTROL OF DISEASES WHERE ALCOHOLIC BEVERAGES ARE SOLD

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The wholesale growth, temporary or otherwise, of beer gardens, or defunct eating houses, hotels or barbecues, to take advantage of the present demand for beer and alcoholic beverages by the general populace, has created a real health menace.

This menace lies in the fact that a large proportion of the persons seeking licenses to open beer gardens and eating houses where beer, or other alcoholic drinks, are to be sold, are unfamiliar with what is meant by proper sanitary arrangements in such places and are also uninformed as to what constitutes a menace to the health of the people.

This lack of information is obviously more prevalent in rural areas than in cities and towns. Most large cities and towns have some form of health and sanitary supervision but up to the present time rural areas are lacking in this necessary control.

It is apparent then that a uniform minimum sanitary code should be drawn up and put into effect to prevent the totally unnecessary spread of various communicable diseases which can be transmitted by contaminated containers of glass or other material.

In the prevention of disease we often make the mistake of looking too far afield for the source, and neglecting everyday causes directly at hand.

Various companies and certain cities for some years have insisted upon the physical and bacteriological examination of food handlers. Unquestionably many sources of infection have thus been found and eliminated.

Attention has also been directed to the sterilization of eating utensils. In some cases these are washed clean but infected later by diseased handlers. A striking example of this was the epidemic of typhoid fever among university students at Madison, Wisconsin, in which a waiter who suffered from a walking case of typhoid fever, wiped and stacked dishes after they had been washed, and infected some forty-one persons.

In New York City an investigation of 1,981 foodhandlers in 1917 showed ten active and fifteen arrested cases of tuberculosis; nineteen active and thirty-two suspected cases of syphilis; and six cases of gonorrhea. Other examinations have revealed similar conditions.

It seems not only possible but probable that patrons of restaurants, beer gardens, etc., in rural areas especially, have been and will continue to be exposed to infection through such means.

It is said that in certain establishments where beer or other alcoholics are sold, glasses have nothing that can be called washing, but are simply rinsed, drained, and used again and again, sometimes without drying.

The mechanical dish and glass washer is coming into more or less general use in hotels and restaurants, and bacteriological examinations show that the results are much better than hand washing, except in those cases where the latter is done with extreme care, with hot water and soap and with clean and hot rinse water. When the rinse water is only lukewarm, there is absence of disinfecting action and in a short time it becomes rich in bacteria.

With hand washing the tendency, of course, is to use water which is not hot enough to scald the operator and consequently is of no value as a cleanser of utensils.

Recently a sanitary survey of beverage establishments in Lansing, Michigan, undertaken by Mallmann and Devereux of the Department of Bacteriology and Hygiene of Michigan State College, East Lansing,

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brought to light the following insanitary conditions:

1. "Few establishments where beer or liquor was sold were attempting proper care in the handling of glassware.
2. "Few places in the entire city had satisfactory glassware.
3. "Many were not even provided with running water at the dispensing bar. Some were merely dipping the glasses in a pail of water which was changed at infrequent intervals.
4. "In a few, wash sinks were located in back rooms inaccessible to the bar.
5. "Appearance of the bar and the wash sinks showed plainly that even rinsing the glasses in water was a rare occurrence in some cases."

If such conditions could exist in the very capital of the state, what must be the case in outlying districts which have no sanitary or health supervision? Homer N. Calver, Fellow of the American Public Health Association, in an article entitled, "A Neglected Opportunity for the Control of Respiratory Diseases," published in the *American Journal of Public Health,* August, 1935, brings out clearly the dangers lurking in the lack of sanitation in food and drinking establishments.

"The control of respiratory diseases," says Calver, "through sanitary measures has seldom been tried thoroughly in a sustained program. While waiting for the laboratory to discover a readier measure of control, this may offer a fruitful means of attack. Sanitation as here considered means the establishment of procedures wherever possible to prevent the mouth discharges of infectious persons from being imbibed by others.

"The only important point at which the Health Officer has it in his power to interpose barriers to this salivary exchange is in his supervision of public places serving food and drink."

With the above reasons in mind, the following sanitary measures are suggested for beer gardens, restaurants, and places where alcoholic beverages are sold in rural areas which do not come under a full time Health Department, or where no such ordinance exists even if a full time Health Department is in operation.

Suggested Sanitary Code

That, before any license is issued to any individual, firm or corporation to dispense beer or other alcoholic beverages in beer gardens, restaurants, barbecues, or other places so designated,

1. The person or persons who work in the above mentioned places must obtain a certificate of health from the Health Department, where one exists, or from some public health agency to be designated. This food handler's permit shall consist of an examination for venereal disease, tuberculosis, and any other communicable disease as might seem advisable. In addition, all workers in the above mentioned places must be examined to determine whether or not they are typhoid carriers.
2. The conditions existing in the beer garden, restaurant, barbecue, or other place designated, must be sanitary and arranged for the bodily well-being of patrons as approved by the Health Department, where one exists, or by some public health agency to be designated.
3. The washing facilities for glasses, dishes, or other eating utensils must be such as will be approved by the State Department of Health and local health authorities.

It is suggested that a qualified physician who is trained in public health and sanitation to be requested to advise on all matters regarding the sanitation of beer gardens and other places where beer is to be sold in rural areas, and that a committee be instructed to draw up a Sanitary Code which will meet with the approval of the State Department of Health.

This article is presented with the earnest conviction that a real menace to the health of the people of Michigan exists under present conditions in the majority of drinking places. These conditions are remediable at a cost not out of proportion to the benefit to be obtained.

MEANDERINGS IN OPHTHALMOLOGY*

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It is only a little more than eighty years ago that modern scientific ophthalmology began. In 1851 Helmholtz[11] described the ophthalmoscope and a few years later von Graefe's[45] Archives sprang into print. With the advent of this publication and others of its ilk, which were to follow, many of the basic principles of our chosen profession were brought to universal attention and recognition. Additions to our knowledge have been numerous of late years, so much so, at times, that it behooves us to pause and evaluate.

With your coöperation, it will be my purpose to bring to your attention, for discussion, various phases of our subject. For the most part the substance of the dogmatic statements made will be from my own teachings and experiences, substantiated as far as possible by experimental and clinical evidence submitted by authoritative sources. The practice of medicine consists in the knowledge of the art and the science of that complex human mechanism which is never alike in any two individuals. It is the duty of the physician to advise his patient both in a prophylactic and therapeutic manner as to those measures which have been cast aside as being found wanting as well as to inform him of the new and proven aids to the body's well-being. Boric acid is soothing for a short time, possibly five minutes at the most, but it has never been known to cure any eye condition. Theobald[43] in 1880, when boric acid was introduced, wrote in glowing terms of the new remedy and reported numerous satisfactory cures in conjunctivitis cases. Of course we know now that boric acid has a negligible germicidal power. Even the layman of average intelligence knows that the so-called eye washes advertised so extensively by each and every manufacturer of cosmetics depends on boric acid for its "eye-brightening" effect. Our efforts should be directed in explaining that the tears are the natural eye-wash and that infection or inflammation of the conjunctiva must be treated by an agent that removes the irritant, allays the irritation or kills or prevents growth of the bacteria causing the infection.

Argyrol has been used by ophthalmologists for about thirty years. As far back as 1906 Verhoeff[44] found that 12 per cent argyrol failed to kill staphylococci in one hour. Derby[6] obtained abundant growth of Staphylococcus aureus after three and one-half hours exposure to 50 per cent argyrol and concluded that argyrol was almost inert but sterile and soothing. Post and Nicoll[37] found that after an exposure of one-half hour pneumococci were not killed by 50 per cent argyrol. However, Lancaster[17] in 1920 published laboratory evidence which undoubtedly greatly influenced the acceptability of argyrol as an antiseptic for use in eye work. He concluded that it was "a powerful antiseptic as tested on staphylococcus aureus in serum or in salt solution or water." To demonstrate what influence Lancaster's opinion made I need only tell you that in the 8th edition of DeSchweinitz' text[7] ten references are indexed under argyrol showing its use as an antiseptic. In 1923 Cheney[3] was so disturbed by the difference in the conclusions of Verhoff and Derby on the one side and Lancaster on the other, that he reviewed the entire experiments of all of these men. He concluded that argyrol has a definite germicidal power *in vitro,* its continual use produces argyrosis, it does not keep well and has little if any power of penetration. Cheney said also that he did not wish to give the impression that he was an enthusiastic advocate of the use of argyrol. In some experimental work of my own, never published, I was able to show that 25 per cent argyrol is an excellent culture medium, and that even from a 50 per cent solution cultures of the ordinary pathologic conjunctival bacteria could be induced to grow after exposure of from one to three hours. Speaking of the silver protein compounds Gifford[9] says, "Their bactericidal effect is very slight, and it is probable that their

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astringent effect is as well secured by the zinc salts, which are free from the danger of staining the cornea and conjunctiva." In spite of all this evidence it is not unusual to be asked to see a child or even an adult where the pediatrician or internist has prescribed argyrol to no avail and finally comes to one of us for help. The oculist who treats his patient with argyrol and gets a good result, in my opinion, would have had a cure by simply praying, as so many of these conjunctival infections are self-limiting. Those of you who are interested in ear, nose and throat work in addition to the eye will no doubt recall the recent report in the *American Medical Association Journal*[8] of seventy cases of generalized argyrosis. I have never heard of a generalized argyrosis due to treating the conjunctiva and yet I cannot see any logical reason for using an inert and disfiguring drug. Even the organic silver salt has its disadvantages. But to this subject I shall refer later in discussing gonorrheal infections.

So far we have heard of two drugs which are useless as conjunctival antiseptics. In very recent years many new preparations have been introduced. Mercurochrome, merthiolate, S-T 37, and metaphen are apparently efficient in proper concentrations. However, my preceptor, Dr. Meyer Wiener, was able to demonstrate to me during a period of five years how very useful is the antipneumococci antiseptic, optochin hydrochloride in 0.5 solution. I am unable to give you definite data as to the reason for its efficacy but I have had the idea that in many conjunctival infections the pneumococcus is either the initial invader or as a secondary parasite exerts the predominating role of infective agent. It must be acknowledged that as far as remuneration is concerned this drug does not add to the cash register, for acute conjunctivitis clears quickly under optochin therapy.

I have always felt that the way to attack gonorrheal ophthalmia is at its source; thus the problem should be one for the obstetrician or the genito-urinary physician. However, these gentlemen for some unknown reason do not seem able to handle the situation properly and thus we see patients with gonococcus conjunctivitis. Lehrfeld[20] has lately re-analyzed the efficacy of the Crede method of instilling 1 or 2 per cent silver nitrate and concludes that it is better to instill a 0.5 per cent silver nitrate solution on four successive days. His figures show that in babies with ophthalmia neonatorum only 28 per cent were gonorrheal, the remainder being for the most part pneumococcic, due most likely to the irritating action of silver nitrate. He recommends sterilization of the birth canal before delivery and a change in the state laws to include prenatal antisepsis. In a previous paper on "The Technic of Nursing Ophthalmia Neonatorum" Lehrfeld[21] stresses many points with which I am in entire accord and wish to bring again to your attention. It has always been my contention that any gonorrheal infection of the eye may be cured if during the first forty-eight hours of the disease *proper* care is given. This means that if drops are to be used, and I prefer a 5 per cent mercurochrome, it is very necessary to be sure the drop gets in the eye. Often in the new-born two or three nurses are needed to undertake this difficult maneuver. The upper lid must be everted and the upper cul-de-sac requires its share of the medication. Thorough flushing is of the utmost importance and depends not on the antiseptic property of the solution used but on the thoroughness with which the stream is able to cleanse the pus away. I hope none of you ever have an experience like I had last year where a graduate nurse was using an eye cup to flush out the conjunctival sac. Ice packs used frequently to reduce the swelling, and foreign protein therapy to raise the temperature and increase the antibodies aid materially in the treatment. In private patients I insist on two graduate nurses for day and night duty, and I tell the nurses the outcome of the eyes depends on them.

From time immemorial we have been warned that the use of a cycloplegic in individuals over the age of thirty may precipitate glaucoma. Most of us teach this idea to our students. Last year Abraham[1] made a statistical study of this problem and concluded from the answers to his questionnaire that the incidence of acute glaucoma following a mydriatic is one in 18,400 cases. Following the mydriatic if a miotic is used the number decreases. He finds that the incidence is increased by prolonged mydriasis, occurs seldom before the age of thirty and suggests that at least some cases would show signs of early glaucoma by special tests if carefully checked. It has been my

good or bad fortune to have seen in the past ten years four cases of acute glaucoma following mydriasis in unsuspected eyes. In none of these was there an unfortunate outcome up to the present writing although I must say that the course of most of them was stormy. It has been my custom to make the rounds of the medical wards at Michael Reese Hospital every Sunday morning for the past five years to enjoy medical ophthalmology with the interne's interest. Only one of these cases previously mentioned occurred in this large series. It seems to me that a person with unsuspected, insidious glaucoma is far better off if such is discovered by accident than if there was no evidence until very late when fields are greatly contracted and extensive atrophy has begun in the eye. I feel very definitely that too much is made of this question and that perhaps more patients with incipient glaucoma could be brought to their own and our attention.

Both Stokes[42] and Moore[35] in their admirable texts acknowledge the beneficial effects of tryparsamide in syphilis of the nervous system. Yet both authorities emphasize that the drug should not be used when optic atrophy is present, and Moore puts his warning in italics. While the ophthalmologist is not called upon to treat syphilis, his advice is often sought to guard against optic atrophy. The numerous reports from the clinical evidence have been contradictory. I shall not take the time to review these reports, with which you are no doubt familiar. Lazar's[19] report originated at Northwestern University, where he and I have continued to watch all patients under tryparsamide treatment, and although we have not as yet reported our findings it is obvious to me from this study and the previous report made in conjunction with Smith[33] that individuals with neurosyphilis treated by tryparsamide are rarely the victims of a complication involving the eye due to the drug. Two thoughts I shall leave with you. The first is the fact that the patient knowing of the possibility of danger to the eye is quite apprehensive and may easily be unduly influenced by suggestion. The second thought is the fact that in the use of almost any drug there are individual susceptibilities and idiosyncrasies. As far as I know, no one has as yet proven that tryparsamide in the dosage usually given is toxic to nervous tissue and I still feel "that tryparsamide, intelligently administered, causes no increase in the atrophy of the optic discs, where syphilis has previously caused changes."[33]

Our colleagues, the internists and likewise the pediatricians, have a viewpoint concerning tuberculosis which is, in a measure, contradictory to our ideas. To them, unless the patient has a demonstrable pulmonary lesion, there is no likelihood of active tuberculosis. I am not entirely satisfied that the ocular lesions of phlyctenulosis, nodular iritis and solitary tubercle of the choroid are due to the tubercle bacilli or whether they are allergic phenomena caused by toxic products of the organisms, but I am certainly sure of the fact that treatment with tuberculin cures these conditions. Many reports[12,14,24,25,28] from tuberculosis sanitaria have all failed to show any of these ocular conditions in these patients with active pulmonary tuberculosis. Of utmost importance is the tuberculin test in patients with suspected ocular tuberculosis. If you do not do the test yourself but leave it to the general medical practitioner be sure to warn him that a very high dilution should be used in the initial tests. I have had the sad experience of leaving the dosage to competent medical consultants and have on one occasion lost an eye following too high a concentration in the skin test. I recently was asked to see a patient with chronic keratoiritis who had been under the care of two ophthalmologists and an extremely capable internist for some three months without benefit. In discussing the case with the internist I found that all the findings were negative except for the Mantoux test. This was markedly positive and even after one month the patient had a local residue of the reaction. "Why did you use the Mantoux test, if you paid no attention to it?" I asked of the internist. "Oh," said he, "we never pay any attention to that test in adults." And this from a man for whom I have the greatest regard. My results have been best with the preparation known as Koch's old tuberculin beginning with a 1 to 1,000,000 dilution and gradually increasing the dosage, always keeping under the dose causing a reaction. The only disadvantage I have found with old tuberculin is the fact that it is necessary to make up fresh dilution every month. We have used tuberculin in reactive eyes following cataract op-

eration with excellent results. Meller's[34] work in connection with Lowenstein's culture of the blood for tubercle bacilli has not as yet been adequately confirmed but it may lead to a better understanding of this entire problem.

Just one remark concerning detachment of the retina, as time will not allow of a thorough discussion of the so recent, abundant material. We are unusually fortunate in this country that the number of eyes with this unfortunate condition are few and far between. Thus it is that any one man sees relatively few patients with detached retina. Each, while listed under the same diagnostic index, is nevertheless different. The point I wish to stress is that each case needs a thorough investigation before operation is recommended. To cite one patient who was sent to me for consultation some six months ago. Four eye men had seen him before I did, two in St. Louis and two in Chicago. The doctors in St. Louis recommended operation, but as neither of them had attempted an operation they sent the patient to Chicago to a man who was reputed to have done quite a few of these operations. This man was out of town but his associate recommended immediate operation. The patient sought another physician who asked for my opinion. I found that patient with bilateral congenital ectopia lentis, many fine floaters in both vitrei which had been present for many years to the patient's knowledge. In the left eye below the dislocated lens involving the lower retina was noted what to me was a broad, flat, detached retina with exudate under it and no tear visible. I advised against an operation, said I would be afraid to chance it (and there is nothing I'd rather do than operate) and told the patient to go home, put himself under the care of his original ophthalmologist together with a competent internist and find out what was causing the exudate. I subsequently heard that the patient went to Los Angeles, where he had an operation and finally had to have the eye enucleated. My point is, beware of the flat, exudative detachment that may be due to localized choroidal disease. I am inclined to agree with Lindner[23] that the so-called idiopathic detachment is due to a diseased vitreous, as was indicated in my experimental work on the vitreous in retinal detachment.[29]

The subject of orthoptic training has finally come into its own and promises great things for the future. Much of this work is familiar to you. It will be my purpose simply to inject a few generalizations for you to keep in mind when the road seems rough in the conquest of a case of squint. In a period of three months time with patience and persistence on your part, with concentration and application on the part of the patient, and finally with the parent's unstinted coöperation, unquestionable progress should be easily demonstrated. If in this length of time the amblyopic eye has not enhanced its visual acuity and the angle of squint is not narrowed, then operation is indicated. The patient should be told two things about the operation. First, that it is done for cosmetic purposes only, and secondly that more than one operation may be necessary. In reviewing the instruments and methods for this training[30] I was and am still convinced that no single one is better than another but that as many as possible should be tried on each individual strabismus patient. The background and many of the methods for orthoptics are not new, as witness the text of Hansell and Reber written in 1912,[10] but the appreciation of and efforts to overcome this defect are having a thorough try-out. We are learning daily and I find myself more and more often postponing operation even in adults until I have a thorough knowledge of the eye musculature and what orthoptic methods will accomplish.

From time to time each one of us sees a patient whom we have to advise that there is nothing further to be done to give him sight. It may be an opaque cornea, a keratoconus, a malignant myopia, a central or cæco-central lesion of the retina or an optic atrophy. At intervals, certain methods which are fortunately seldom needed should be recalled to mind lest we forget that such drastic and radical procedures are available in extreme affections. Transplantation of the cornea as discussed by Castroveiji[2]; resection of the cornea as devised by Wiener[46]; the contact glasses of Muller[36] and Zeiss[47]; the telescopic spectacles with their startling results[27]; the shortening of the eyeball by Lindner's[22] method; the resectioning of the carotid sympathetics according to Magitot[26]—all these are methods of last resort in severe conditions.

As a fitting dessert to this hash-like repast which has been served up to you, I should like to conclude with a mention of

some of the newer tid-bits contributed to our specialty which have impressed me.

Jameson[13] is advocating the use of thyroxin in certain eye conditions, where it may be assumed that the patient's general condition prevents an early and satisfactory outcome. The idea is that the hormone stimulates those factors so necessary for cure. He has had some very satisfactory results.

Selinger[40] has had excellent results with the local application of a 10 per cent quinine solution in both the treatment of trachoma and the removal of corneal opacification.

A preliminary report of a new method of perimetry by means of minimal light flashes has been published,[32] and this method has demonstrated to me an easy, more accurate and untiring technic which bids fair to make this examination one of routine in office practice.

Lauber[18] has called our attention to the work accomplished by his associates[41] concerning the relation of intracranial and retinal intravenous pressure. These workers are of the opinion that measurement of the pressure in the retinal vein is a direct indicator of what is occurring in the cranial cavity. If this hypothesis is confirmed it may be a big step forward in the diagnosing of intracranial affections.

Two Russian authors[16] have found that a one per cent alcoholic solution of brilliant green is effective in ulcerative blepharitis. While we rarely see cases of this stubborn condition, at times it has responded well to such therapy. Coppez[5] has made a decided advancement in the type of electrode to be used for retinal detachment. By an ingenious device the temperature of the fulgurating needle is known at all times. Dr. Arnold Knapp[15] of New York recently made a study of the various methods used in detachment of the retina in the European Clinics, and his enthusiasm for this new electrode of Coppez recommends it very highly.

Ruedemann[38] believes that a study of the conjunctival vessels and their reactions in health and disease will add much to our knowledge of ocular conditions. We are awaiting with great hopes his further reports.

Again the subject of tinted lenses has come up for analysis. Coblentz[4] has definitely decided for us that up to the present time the manufacturers of these colored glasses have no basis whatsoever to recommend their use. Wide angle lenses have also received their share of criticism.

The injection of the patient's own blood into the anterior chamber for tuberculous iridocyclitis as proposed by Schieck[39] has found many advocates and indeed seems to have a definite place in our armamentarium of treatment for such resistant conditions.

More and more, because of the new trend in educational methods, where the teaching of the alphabet is a thing of the past, we are seeing those misguided children with partial word blindness.[31] Labeled mental defectives, which they are not, they are usually grouped with the feebleminded, and allowed no chance to achieve the excellent prognosis which we have come to know is their just due. With the dissemination of the knowledge of this curable condition it is to be hoped that educators will give proper recognition to the possibilities of these wayward children.

Time and space does not permit of further additions to this pot pourri of interesting eye subjects.

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MEDICAL PRACTICE IN SWEDEN*

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State medicine was established in Sweden as early as 1662. In that year a royal decree authorized the Medical College in Stockholm to exercise complete authority over all people practicing the healing art. This included the physicians, barber surgeons, stone and hernia cutters, oculists, chemists, bathers, masseurs, dentists and apothecaries. The State Government appointed a governing body which has become known as the Medical Government. This has gradually crystallized into its present form with a set-up about as follows:

A director general and five medical councillors. The director general and four of the councillors must be legitimate physicians, and one a veterinary. The department is further served by one secretary, one registrar, three notaries, two auditors and one cashier. Besides there are: one prosecutor, one representative, one chief inspector for mental diseases, one controller of hospitals, one chief architect and a number of clerks. For bacteriologic examinations and medico-legal investigations there is a State Medical Institute.

Management and Control

The Medical Government has complete control over public health matters as well as the care of the sick; everything concerned with medical service comes under its authority. It has control over all who practice the healing art as well as pharmacy. The only exception is that of University professors as such. It governs the country's asylums and the care of the mentally ill; it also has control over all general hospitals, baths, spas, and other curative institutions. The pharmaceutical, dentistry, midwifery, veterinary professions, medical gymnastics and massage institutes are all included under the authority of the Medical Government. The Medical Government is required to furnish information that is necessary to carry

*The writer of this article has been invited on several occasions to write or speak on the subject. He has invariably declined for fear of becoming accused of seeking to reform our own status of practice or import something which could not easily be applicable to this vast country. In the spring of 1935 a symposium was given on foreign medicine at a regular monthly staff meeting of the surgical staff of Harper Hospital. The writer presented the Swedish side essentially as given in this article.

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on the function of courts, to assist in solving medico-legal problems and other technical details for the community and public authorities. Finally it supervises the care and prevention of epidemics, infectious diseases, methods and control of smallpox vaccination.

Drugs and other pharmaceutical products, including prices, are under control by the same government. Price levels are revised annually by aid of pharmacists. Drug stores are regulated in proportion to population; they deal only with medical supplies. In a general way the system resembles markedly our Army Medical Service.

Ratio of Physicians to Population

In 1925 there were 2,014 registered physicians in Sweden. Of these, 1,236 were civilian government physicians, 681 were in private practice and 97 were not in practice. In cities there were 1,347 physicians, while 570 practiced in the country. In Stockholm the ratio of physicians to population is the highest, one to 822, in contrast to one to 3,150 in the country as a whole. In Stockholm, where is concentrated the greatest wealth of the country, are the greatest number of privately practicing physicians, the ratio being 284 private to 222 government physicians.

The Cost of Medical Care

The cost of medical care is covered by taxation to the extent of 80 per cent of the entire cost. To be exact, in 1925, 21 per cent of the population paid for their own medical care. Of civil patients in military hospitals, 16 per cent paid their own expenses. The balance was paid for by the community and State Government. The average cost per patient per day in 1925 was $1.80. This does not include expenses for additional buildings or reconstructions.

Separate Services

Regarding the different medical services, the following may be said:

Venereal Diseases.—The law requires that venereal disease be combated by prophylaxes, education in sex hygiene and treatment. It provides: (1) Medical care either in hospitals or by ambulatory treatment for all patients suffering from venereal disease; (2) the privilege of obtaining the necessary treatment free of charge; (3) that it is the duty of patients to observe the plans and treatments as given by the physician; (4) a system of instruction and public enlightenment of the problem. There has been a great reduction in the incidence of venereal diseases since this law became effective in 1919. During that year there were reported 5,823 new cases of syphilis; in 1924 only 850. In 1919 there were reported 18,471 new cases of gonorrhea; in 1924 only 10,299. The more effective means of combating syphilis than gonorrhea explains the more favorable figures in that disease. It is believed by the authorities that the most important reason for the general improvement is due to free treatment. Prostitution, under medical control, was discontinued in 1919 by the same law which provided for compulsory treatment of venereal diseases. Neglect on the part of the patient is punishable by fine or imprisonment.

Tuberculosis.—This disease is rather prevalent in Sweden, like in most countries situated far north. Due to an intensive anti-tuberculosis campaign there has been a very marked improvement in the death rate. The local as well as State Government is behind both the educational and curative work. In addition there are four national sanatoria located so as to be geographically of the greatest advantage. These are financed by a five million crown fund which was donated by King Oscar II in 1897 in memory of his twenty-five year reign. The sum was collected by public subscription as a gift to the King, who in turn decided to use it for this purpose. In addition to the above, the anti-tuberculosis work is efficiently and effectively carried out through the means of special dispensaries, polyclinics and visiting nurses. All of these agencies are supported by the government.

Acute Infectious Diseases.—These cases are required to be reported at once by the attending physician and are hospitalized in so-called Epidemic Hospitals without cost to the patient. The so-called carriers of infectious diseases are also isolated in these hospitals and cared for at government expense.

Status of the Physician

The State Medical Service is conducted by physicians who are engaged and paid by the communities and State Governments. Some of these physicians are full time men giving their service to general hospitals or to tuberculosis sanatoria. The

general hospital physicians are paid by the local community which they serve, like a city, town, or county. The sanatoria physicians are paid partly by the local and partly by the State or Federal Government since the care of tuberculosis cases is considered a national responsibility as well as a local one.

The greatest number of physicians, however, are not attached to the hospitals but are general practitioners known as provincial and city physicians. The entire country is made up of twenty-four provinces, corresponding in a sense to our states, though much smaller. In each province are the first provincial physician and extra-provincial physician, a matter of grading in accordance with length of service. In the city we have chief city physician and city physicians who are charged with the same responsibilities as the provincial physicians. These physicians are paid according to a graded scale decided by the Medical Government. In addition the towns and smaller communities have physicians and pay them according to a universal scale.

The General Hospitals

Below is a very general view of the function of a General Hospital in Stockholm; a typical city hospital. It represents the financial report as part of the annual report to the city council. The report is very comprehensive in scope; it is printed annually and covers the major activities of the hospital. The name of the hospital is Mary's Hospital; the report is for the year 1931 and is signed by the director, Dr. Einar Key. The capacity of the hospital is 241 beds. Of these 105 are medical, 136 surgical. Total admittance during the year was 4,371, of which 1,779 were medical, 2,719 surgical. Of those admitted 236 died, a little over 5 per cent. The average number of patients per day was 249.9, of which 105.6 were medical, 144.3 surgical. The highest number of patients on any day was 304, the lowest 175. The average length of stay in the hospital was 20.9 days, the medical cases averaged two days longer than the surgical. The charge per patient per day varied: for private rooms, $1.00 to $4.00; semi-private $0.50 to $3.00; ward beds entirely free or from $0.25 to $2.00 per day. Of the total 4,371 patients admitted, 19 per cent or 816 were free.

The expenditures for the year totaled $253,550. Of this amount $80,473 was collected for beds or polyclinic fees. The balance, or about two-thirds, was paid by the city. The total expenditures included additions to buildings, repairs and maintenance of buildings and apparatus, medical supplies, ambulance service, funeral expenses, chaplain and organist services, plus all salaries paid to staff, nurses and labor—the only exception being that the chief surgeon is paid by the University Medical School where he is professor of surgery; as director of the hospital he receives only a very small compensation from the hospital. By including all the above items in addition to buildings, property maintenance, et cetera, the total cost per patient per day is $3.55. By excluding these items the cost for the actual medical care becomes $2.25 per patient per day.

Pay of Trained Personnel

Concerning the remuneration paid the staff and trained personnel we quote these figures: the director, $300, but he receives his actual living income from the University as professor of surgery, which amounts to $3,000 plus compensation for quarters, heat and light. The residents in surgery, medicine and roentgenology receive $2,000 each. The assistant resident surgeon, $1,200; the assistant resident physician, $750. The seven house physicians receive $1,400. This staff receives in addition quarters, food and laundry. The electro-cardiologist, $500, the pathologist, $1,000. None of these are residents. The chief operation room nurse and the roentgen department nurse receive $750 each plus quarters and maintenance. The nineteen trained hall nurses $600 each plus quarters and maintenance. Extra nurses receive the same. Laboratory technicians, $600 plus maintenance. In addition there are three period increases ranging from $75 to $150. The resident chiefs of the departments are allowed to charge nominal fees for services rendered out of town patients. This means that a patient coming from out of town is charged full amount for bed and professional services. The director of the hospital, also professor of surgery at the University, is allowed to carry on a limited private practice. He is non-resident but owes his first duties to the hospital and teaching. The entire personnel enjoys security for old age by a system of pensions in accordance with position held

during active years. In each of the twenty-four provinces is a main central hospital. It is run about the same as the one described above with the difference that the cost is proportionately lower and the personnel receives lower rates of remuneration. A very comfortable home usually adjoins the hospital for the chief surgeon and his family. He is always a full time man.

Cost to the Patients

In deciding the different rates to be charged a patient admitted to the hospital, the following procedure is generally practiced. The public requiring the hospital service is divided into these three income classes. The indigents who are paid for the welfare department at the very lowest rate; the lower income class, up to a certain average annual income which is known through the department of taxation. These are also charged the lowest rate: about $0.35 per day. The second class, or the great middle class whose income is limited and known through tax records, pay a rate of about $0.55 per day. The remaining class, the people who live in relative comfort, pay the highest rate of about $1.00 per day. After thirty days in the hospital there is a proportionate discount in rates for all classes; these are all for ward beds. There is a difference in charge for private or semi-private rooms. Also, patients coming from another province are charged proportionately higher; in other words the full cost of hospitalization. This applies to the country as a whole rather than the capital cities. The larger hospitals have well run polyclinics. A first charge is made of $0.55 and after that $0.30 for each treatment. After ten treatments there is no further charge. Those who can qualify as indigents are cared for entirely free.

Ambulance Service

The transportation of seriously ill patients to hospitals is usually taken care of through an ambulance service which is run by the fire departments at the expense of the local government. In the larger cities there are in addition private ambulance services. As early as 1923 airplane ambulances were used to transport seriously ill patients to hospitals, especially from the northern parts where roads are poor and distances great.

Cancer Control

For the study, control and treatment of malignant tumors, Sweden has exceptional facilities. The central institute, located in Stockholm, is known as Radiumhemmet. It was established in 1910 by the surgeon, John Berg, and its present director, Gösta Forssell. This is the centrum for all radiotherapy in Sweden. It has complete facilities for research, diagnosis, treatment and statistical studies of malignant diseases. It is maintained by funds contributed by the city of Stockholm, the State Government and private donations. The largest of these is the million and a quarter dollar fund known as the King Gustaf Jubilee fund which was subscribed to by the entire population in honor of the King's seventieth anniversary. There are two smaller radiotherapy institutes in southern Sweden, each controlling 1.5 gms. of radium. The Radiumhemmet controls about 5 gms. of radium and has complete installations for roentgen therapy. It has an elaborate staff of highly qualified men who carry on the work in an efficient manner and are in close contact with the entire medical profession of the country. This has encouraged a lively interest in the cancer problem and early diagnosis of the disease. The system of follow-up and statistics is very good as illustrated by the following figures: from 1914 to 1928 there were 1,644 patients treated for carcinoma of the uterus. The outcome of each case is known. From 1921 to 1928 there were 255 breast cancers treated. Of these only two were lost track of, one having emigrated to the United States. A polyclinic is connected with the institution. The cost for ward beds is $1.00 per day; for private rooms, from $3.50 to $4.50 per day. The average fee for radium treatment for ward cases is $1.25; for deep roentgen therapy $0.75 to $1.50. Patients unable to pay their way are furnished transportation by the government. Their local home governments pay half of the cost of the bed and treatments, the balance is furnished by the cancer fund. The referring physician is given every coöperation and kept informed about the patient's progress on special report cards.

Maternity Service

The obstetrical service is rendered principally through midwives. These are trained in two institutions for midwifery, one in Stockholm, the other in Gothenburg. The course takes two years and approxi-

mately sixty midwives graduate annually. The entire training is conducted at the expense of the State Government. At least every ten years a midwife is obliged to take a two-week postgraduate refreshing course, either at a special hospital or at one of the teaching institutions. For this she receives special remuneration as an encouragement. The entire country is divided into 2,000 obstetrical districts, each area depending upon the rate of population. In each province is a board of obstetrics, the chairman of which is the first provincial physician. There are strict rules governing when or where a special surgeon should be called when complications occur. The district midwives receive a base pay by the State and local community and the fees are according to the ability to pay or entirely free. The care of the newborn is also one of the duties of a midwife. Old age security is provided for by a pension system as for the medical profession.

Cults

The proper training by the government of sick gymnasts and masseurs has prevented the appearance of cults and irregular healers to a large extent. In the out-of-the-way places, however, there is quackery to deal with as in most countries throughout the world.

Conclusions

This represents in a general way the present system of medical practice in Sweden. It is a system which apparently is well adapted to a small country of a homogeneous people. The system is sufficiently flexible to become adapted to the changing economic trends, and still be satisfactory to the profession and public alike. Sweden has a population of approximately six and one-half million people; a homogeneous race which has inhabited that large northern peninsula for more than 10,000 years. It is the oldest country in Europe which has been continually inhabited by the same race. It has been a unified kingdom for 1,200 years. Its laws, quoted from Agnes Rothery's recent book on Sweden, "help to promote health and give education to every child, to control its powerful men, and strengthen his weaker brother."

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PREVENTION OF CANCER*

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The present day methods of treating cancer by means of surgery, x-ray, and radium have probably reached their peak of perfection and will be difficult to improve upon until the actual activating agent in the production of cancer has been found. Efforts to reduce the mortality rate have been directed toward making earlier diagnosis before spread and distant metastasis have occurred. Considerable progress in this direction has been made, but, as yet, the field of prevention of cancer has been more or less neglected although it gives promise of great possibilities.

The purpose of these remarks today is to call your attention to a few of the many definitely established precancerous lesions and point out how the alert physician may lower the incidence of cancer by recognizing and removing these pre-cancerous hazards.

Cancer has attained a very important place in the lives of American people. It ranks second as the cause of death in the United States registration area and, according to statistics, approximately one person in each thousand dies of cancer annually. The general public and a considerable number of practitioners do not yet realize that a very large percentage of these cancer deaths is preventable. To a certain extent cancer is a preventable disease. Certainly there is a stage in the life history of practically every cancer in which it is curable. Then why does cancer rank second as the cause

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of death in the United States? There are several answers to that question but, allowing for the silent nature of early cancer growth, perhaps superstition and ignorance on the part of the general public and lack of knowledge or lack of initiative on the part of the general practitioner would cover most of it. Up to a very short few years ago, the public spoke of cancer in hushed voices and it was almost considered a family disgrace to have a member of the family succumb to that dread disease. It was the general custom of the doctor to hide the diagnosis from the patient. This attitude was probably justified because the patient and his doctor only knew and recognized cancer in the advanced hopeless stages. Textbooks described the symptoms of cancer to be anemia, loss of weight, palpable tumor, enlarged glands, etc., and the recent graduate had only seen the typical textbook hopeless type of case in the wards of the medical school. He knew no other. However, under the guidance and teaching of such well known cancer research workers as Bloodgood, Ewing, and others, cancer has emerged from that cloak of ignorance and superstition which formerly surrounded it. While the exact cause has not been found a great deal of practical information has been learned about cancer. It has long been a popular belief, both in and out of the medical profession, that cancer was caused by some mysterious ultra-microscopic germ or virus. Extensive research has failed to discover this germ and the best medical opinion of today supports the view that, while the exact exciting stimulant to cancer growth is still unknown, the essential underlying cause of cancer is long-continued chronic irritation of a physical, chemical, or inflammatory nature. This hypothesis brings a large number of cancer growths within the field of preventive medicine. Research and long observation have shown that many common chronic irritations are definite forerunners of cancerous growths and have been designated as precancerous lesions.

There may be some confusion as to exactly what is meant by the term pre-cancerous lesion. In general, the term indicates a benign lesion which experience and observation have shown to have the possibility of becoming malignant, although such change is not necessarily inevitable. In other words, carcinoma develops often enough in such benign lesions to warrant the designation precancerous. Such lesions are numerous and of many different types. Included among these are many of the very common everyday conditions which the general public and many physicians consider harmless and to which they give little heed. Hyperkeratosis of the skin, leukoplakia of the mucous membrane, pigmented moles, cracks and fissures about the lips and tongue, chronic infection of the cervix, and small nodules in the breast are a few of the painless, often unnoticed, benign lesions to which little attention is given, yet these so-called benign lesions are the forerunners of cancer in a large percentage of cases. To recognize and remove such lesions is a real step in attacking the cancer problem and in preventing a large number of certain types of cancer.

The general practitioner plays a most important role in cancer prevention. He must be "cancer-conscious," so to speak, and be on the lookout for precancerous lesions in his daily contact with his patients. If such lesions be found, it is his duty to impress upon the patient the dangerous nature of the lesion, and see to it that it is removed or corrected. By advocating annual physical examinations to his adult patients with the idea of preventing cancer, as well as other conditions, the alert general practitioner will aid materially in reducing the high annual cancer mortality. Bloodgood has gone on record as advocating annual or even semi-annual pelvic examinations of all women who have borne children with the idea of preventing cancer of the cervix. He considers this just as necessary a prophylactic measure as the giving of toxoid injections to young children to immunize them against diphtheria.

As everyone knows, there is no simple blood, urine, or skin test to reveal the presence or absence of cancer. However, with the instruments at hand today, a fairly accurate diagnosis of early cancer can be made if the presence of a newgrowth is suspected and looked for. The main thing is to keep the possibility of cancer in mind and look for it before it has advanced to the stage where its presence is obvious. It stands to reason that if a physician is cancer-minded and on the lookout for pre-cancerous lesions in his daily contact with his patients, that he will discover an occasional

early cancer in the stage in which it is curable.

While the entire scope of pre-cancerous lesions is far too extensive to be included in these remarks, I shall point out a few of the more common ones which the general practitioner sees daily.

Cancer is more common in the female sex than in the male. Death statistics show that in 1930 over 11,000 more women died of cancer than men. The reason for the difference in the two sexes is that the reproductive organs and the breast are very common sites for cancer growth in women. Again quoting the 1930 death statistics, nearly 25,000 women died of cancer of the breast and uterus combined. The astounding fact is that the uterus and breast provides the most likely fields for the prevention of cancer, and many of these deaths could have been prevented. The danger of a lump in the breast has been preached to the public and medical students for the past two decades but how many physicians include palpation of the breast as a routine in their examination of female patients; how many physicians have the possibility of a pre-cancerous lesion of the breast in mind during the examination of women patients. It is a well known fact that carcinoma may develop in a previously benign or innocent tumor of the breast. It is also well known that carcinoma cells may be present in what clinically appears to be a benign or innocent nodule. It is impossible to make a clinical diagnosis regarding early malignancy of the breast without removing the entire tumor and examining it microscopically. Removal of a small nodule in the breast is a comparatively minor operation with practically no risk and, as a general rule, most women will gladly undergo such operation if the situation is adequately explained to them. The alert physician who includes examination of the breast in the routine examination of his women patients with the thought of a possible precancerous lesion being present, and, if such a lesion is found, sees that it is properly removed and microscopic examination made, performs an inestimable service to his clientele. If the tumor proves to be benign no one can accurately foretell whether or not carcinoma would have developed but the hazard is removed, and, if this practice were general among physicians, the incidence of carcinoma of the breast would be materially reduced. On the other hand if the apparently benign lump in the breast proves to be an early carcinoma the patient has an excellent chance of permanent cure by radical operation, thanks to its early discovery. The general practitioner has an unequaled opportunity of discovering the early unsuspected carcinoma of the breast if he will but keep the possibility in mind when he examines his women patients for other complaints. If a carcinoma of the breast is undiscovered until large enough to attract the patient's own attention, the chances of axillary involvement are over 50 per cent. Stout, in his monograph on human cancer, states that in a large series of his cases metastases were present in 53 per cent of cases operated one month or less after first discovered.

Cancer of the cervix is another very common cause of death among women which enters the field of prevention in a large number of cases. This type of carcinoma is notoriously a disease of women who have borne children, the incidence being placed at 98 per cent, 97 per cent, and 90 per cent by such well known gynecologists as Cullen, Sampson, and Graves respectively. The essential difference between the cervix of the woman who has borne children and one that has not is that the cervix of the former has been subjected to the trauma of childbirth with inevitable stretching, laceration and, in many cases, subsequent endocervicitis, erosion, eversion, et cetera. It is the chronic irritation of these unhealed cervical lesions that is believed to be the precursor of malignant change in the cervix of the parous woman. Many of the most noted authorities of today (Ewing, Bloodgood, Davis, TeLinde and others) consider endocervicitis, erosion, etc., to be a definitely precancerous condition. Complete eradication of these chronic inflammatory lesions of the cervix is a definite prophylactic step in the prevention of cancer of the cervix as is shown by many convincing reports of several well known gynecologists.

Smith and Pemberton report a series of 1,408 cases, and Bartlett and Smith a series of 1,700 cases of endocervicitis treated by cauterization in which not one was known to have developed subsequent carcinoma of the cervix. Hunner reports a series of 2,695 cases of chronic endocervicitis treated by either cauterization or amputation, not one of which had developed carcinoma ten years later. On the other hand, Bartlett and

Smith report a series of 673 cases of carcinoma of the cervix in which only one had received previous cauterization. In a series of 926 cases of malignancy of the cervix Johnson and Tyrone report that only ten had previously received some type of repair of the cervix including cauterization, trachelorrhaphy or amputation.

The evidence just quoted is sufficient to show that many cases of carcinoma of the cervix can be prevented. The important point is that every married woman should have a speculum examination of the cervix included in the routine physical examination, and any chronic infection of the cervix adequately treated and eradicated as a prophylactic measure.

The manner of treating chronic endocervicitis is important. Time and experience have shown that topical applications in the treatment of the chronically infected cervix are most ineffectual. There are three very efficient methods of treating this condition, namely, trachelorrhaphy, electrocoagulation, and electric cauterization. Trachelorrhaphy requires hospitalization and an anesthetic and is thus generally contra-indicated unless the patient requires other coincident surgery. Electro-coagulation is an office precedure which gives excellent results. However, the apparatus required is expensive, and the majority of general practitioners do not possess the necessary diathermy machine. The electric hair-pin cautery is a comparatively inexpensive apparatus requiring ordinary skill in application. Cauterization of the infected cervix can be done as an office procedure without an anesthetic, and, with the proper technic, the cervix will be entirely healed within six weeks.

Cancer of the lips, tongue, gums and oral cavity are a very important group of neoplasms which occur chiefly in men and, to a certain extent, enter the field of preventive medicine. It has long been recognized that these carcinomas are frequently incited by chronic irritations occurring over a prolonged period of time and are intimately associated with leukoplakia secondary to heavy tobacco smoking, syphilis, and chronic irritation set up by irregular or jagged teeth, poorly fitting plates, bridges, et cetera.

Leukoplakia is a hyperplasia of the mucosal epithelium with heaping up of the superficial layers to form thick white patches or plaques and is comparable to the hyperkeratosis of the skin. This leukoplakia frequently occurs on the mucous membrane of the lip, tongue, gums, cheek, et cetera, and is the most important precancerous lesion in and about the mouth. Another important precancerous lesion is a fissure or crack in the lip or tongue which heals with difficulty or recurs on very slight provocation.

The routine examination of every adult male, and female too, should include a very careful inspection of the lips and oral cavity, with the possibility of finding a precancerous lesion being in the examiner's mind. If leukoplakia, fissure, etc., be found it is the physician's duty to explain the situation carefully and see to it that the lesion is removed.

Cancer of the skin usually develops in the plain sight of the patient and occasionally in sight of the doctor also. The vast majority of these skin carcinomas develop in men and a considerable portion of them are preventable. The senile keratoses about the face and hands of advanced middle-aged and elderly people are notoriously precancerous lesions and should be dealt with accordingly. Basal or squamous-cell epitheliomas very frequently develop in these slightly thickened, scaling, pigmented patches of hyperkeratosis, and such precancerous lesions should receive prophylactic radio-therapy whenever found. Moles are probably the most common skin lesions found in the white race. There is hardly a person living who does not have one or several. The vast majority of these moles are harmless but occasionally a mole is so situated that it is subject to frequent irritation, and it then changes its characteristics to become an aggressive metastasizing cancer of the greatest malignancy. For this reason such moles should be routinely sought for and removed before malignant change has occurred.

Sebaceous cysts are not usually considered as potential carcinomas but Caylor found that epitheliomas developed in over 3 per cent of 224 cases. This percentage is high enough to consider the sebaceous cyst as a pre-cancerous lesion and to justify its surgical removal when found. There are many other pre-cancerous skin lesions but those mentioned are the most common.

Malignancy of the intestinal tract and internal organs is rather more difficult to pre-

vent but here again there are certain definite precancerous lesions with which the physician should be familiar. Ulcer of the stomach, and polyps of the colon and rectum, are the most common in the gastro-intestinal tract. If a patient is known to have one of these lesions and does not consent to its removal, the alert physician should stress the importance of, and insist upon, annual or periodic check-up in order to detect any carcinomatous change. "Gall stones" is a fashionable disease nowadays, but how many patients or their doctors consider the possibility of carcinoma developing in these gall bladders? Yet well over 75 per cent of cases of carcinoma of the gall bladder are associated with pre-existing gall stones. It is true that only 4 to 8 per cent of all cases of cholelithiasis develop cancer but it is worth considering when gall stones are known to be present.

There are many other pre-cancerous lesions which should be removed or corrected but time and space do not permit their mention. In closing I would like to stress that it behooves each one of us in the practice of medicine to become informed regarding pre-cancerous lesions and realize that the medical profession can do a great deal in reducing the great cancer mortality in American life.

BLASTOMA OF THE ADRENAL

A Case Report

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Malignant tumors appearing in young children are not common and their study often presents interesting problems. I therefore wish to add this case to those previously reported in the literature.

The patient, a four-year-old boy, was first seen during the last of May of this year. At that time he was complaining of pains in the legs, and his parents had noted a difficulty in walking, a toeing out and widening of his gait. The pains in his legs were spasmodic and radiated to the upper extremities and neck. He had been losing weight and apparently at this time was developing a secondary anemia. He was placed on a tonic for further observation and on June 10 was admitted to Mercy Hospital for study. His father and mother are both healthy and he had one younger brother in good health. His birth was normal, and his birth weight was 10 pounds 3 ounces. He had had measles and chicken pox but otherwise had not been sick since birth. On admission he had a temperature of 100, pulse 130 and respirations 28. His normal weight before illness was 35 pounds but he had lost sufficient weight to appear emaciated. His pupils reacted normally to light and accommodation and were equal. The lids were normal in appearance and activity. The tonsils were not enlarged and normal in appearance. Dentition was normal without evidence of infection. The lung expansion was equal, and there were no râles or areas of abnormal dullness. The loss of weight made the costal cartilages a little prominent but there was no tenderness over these points. The cardiac dullness extended from the sternal line to one centimeter to the right of the left nipple line in the fourth space. There were no murmurs and the beat was regular. The abdomen was distended as by gas but there were no palpable tumors. The liver was not enlarged and spleen was not palpable. The legs aside from their thinness were not abnormal in their appearance. The reflexes were active. There was no Babinski or ankle clonus. The joints appeared large probably from the loss of weight but were not tender on palpation and there was no redness. To summarize, the patient complained of pains in the legs, and showed distension of the abdomen, with loss of weight and a temperature.

The urine showed no albumen or sugar, was alkaline and cloudy. There were no casts, pus, or blood. The red count was 3,620,000 and the white count 18,400 with 65 per cent hemoglobin, 64 per cent polymorphonuclears, and 28 per cent small lymphocytes. An x-ray of the chest showed normal lung and heart shadows.

Considering the fact that the anemia and temperature might be from a blood-borne infection a specimen of the blood was sent to the state laboratory for study. The culture was negative and so was the Widal. But agglutination with both B. abortus and B. melitensis was positive. This reaction, together with the leg pains, distended abdomen, temperature, and secondary anemia prompted a diagnosis of undulant fever, and treatment was immediately started with undulant fever vaccine according to the method of Dr. Walter Simpson. I started with 0.25 c.c. every third day, gradually increasing to 1 c.c. During his six days in the hospital the temperature varied from 100 to 102. He appeared slightly improved on discharge and was sent home to continue the vaccine therapy.

During June and July he had exacerbations and

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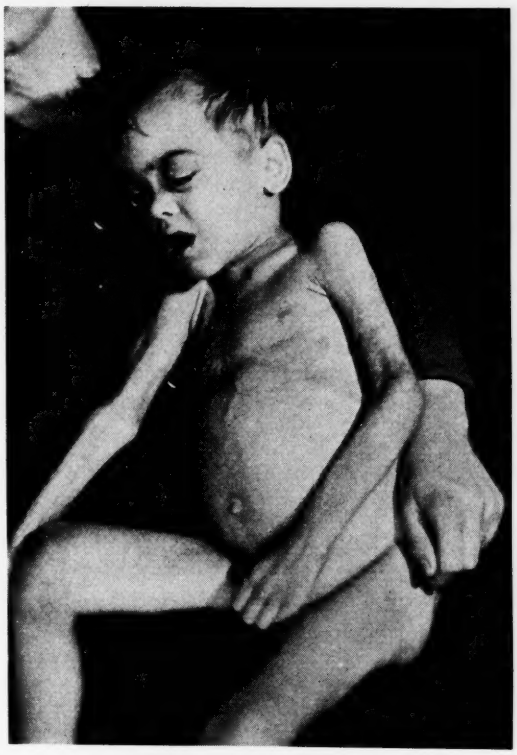
remissions. Near the end of July he began running a higher temperature and developed some vomiting. He was quite restless and developed a cry or whine resembling that seen in meningitis. A few palpable nodules were felt through the abdominal wall which were thought to be mesenteric lymph nodes. The



Blastoma of the Adrenal.

heart dullness had extended outward to the nipple line and at times a click was heard resembling that found in anemia.

A consultant saw him and concurred in the diagnosis of undulant fever, stating that the palpable nodes in the abdomen were frequently found in this condition. He suggested blood transfusions and also luminal for the restlessness which by this time was quite troublesome. He was again admitted to the hospital on July 29 with a red count of 2,390,000 and 45 per cent hemoglobin. The urine was negative except for an occasional granular cast. He was found to be a type one and was given four transfusions by the Scanell method of 120 c.c. each over a period of nine days. A group four donor was used. The red count rose to 2,960,000 and the hemoglobin to 55 per cent. The white count on three tests varied from 11,500 to 14,500. His vaccine was continued as before and after discharge appeared to improve quite rapidly, his temperature remaining below 100 until the last of August. The distension of the abdomen became less, and in general he was somewhat stronger. But during the first half of September he grew worse and at this time a distinct bulging of the eyes, an exophthalmos, appeared. The parents stated that it had slowly been developing during the past few weeks. He was sent to the hospital for three more transfusions. The blood count on discharge was 3,530,000 and 7,900 whites. A barium enema was done which showed a normally filled colon slightly distended. About two weeks later, the abdomen was examined and found large but softer and on palpation a tumor mass was found in the right side which was irregular in outline, about the size of a grapefruit, not notched like a kidney and apparently separate from the liver. The mother stated that it had become noticeable a few days before as the abdomen softened up. Also a lymph node had appeared in the right groin about the size of a walnut. On October 16 after a transfusion of 150 c.c. of blood, this gland was removed and sectioned. X-rays of the chest at this time showed an enlarged heart but negative lung shadows. There were small decalcified, punched out areas in the head of the right humerus, and also large decalcified areas resembling bone destruction in the occipital bone and spicule formation near the vertex of the skull. The report on the biopsy was a metastatic malignant neoplasm composed of small undifferentiated spherical and polyhedral cells. Our conclusions therefore were sarcoma originating from embryonic tissue possibly teritoma of the right kidney, with metastasis to the skull and right humerus.

From this time on he rapidly grew worse. The exophthalmos remained but not constantly, subsiding at times to near normal in the right eye. The left eye gradually developed an edema of the lid with protusion of the ball. The abdomen became larger and harder. His appetite continued good. Bowel action was obtained only with enemata. The veins of the abdominal wall became large and dilated, a collateral circulation. The head grew larger, causing a separation of the sagital suture line, and large prominent fontanelles. Edema of the legs developed and later involved the lower side of the body as he lay on his bed. Luminol was given in gradually increasing doses which later gave no relief and was discarded for codein which was used frequently in half grain doses. He was able to sit up on his mother's lap until the last, and at 12:40 on December 5 took some milk while sitting up. He died twenty minutes later.

Autopsy Report.—The body was that of an emaciated male, aged four. Rigor mortis was not present. Superficial veins of the chest and abdomen were markedly dilated. The head was enlarged and the anterior fontanelle was open and measured three centimeters. The suture lines were separated. The frontal and parietal bones were honey-combed and soft.

Chest.—The left pleural cavity contained about 1,000 c.c. of a brownish fluid. The lung was collapsed. The right lung was macroscopically negative. The heart was normal in size and was not removed.

Abdomen.—The intestines were distended. They were partly adherent posteriorly to a large retroperitoneal mass which filled the entire posterior part of the cavity and involved both kidneys. The appendix was long and extended over the front part of the mass to which it was adherent. The left kidney was involved in the mass but contained no neoplasm. The growth extended through the diaphragm and filled the posterior mediastinum. The anterior bodies of the lumbar vertebra, the ribs, and the left innominate bone showed evidence of invasion by the neoplasm.

Head.—The ventricles were widely dilated and filled with a semipurulent fluid. The meninges were congested and covered with a cobweb appearing membrane showing small hemorrhagic areas. The brain was soft but showed no neoplasm. Just back of the left orbit there was a soft very bloody mass 4 cms. in diameter. This was entirely degenerated and collapsed when removal was attempted. The frontal and parietal bones were honey-combed by metastasis from the neoplasm.

Microscopic Report.—A diffusely spreading and metastasizing malignant neoplasm having the general structure of a small round cell alveolar sarcoma. In the portion of the neoplasm invading the kidney an added feature appears in the form of small

tubular structures lined by a tall columnar epithelium. All the features of this tumor including the age of the patient combine to place it in the group of teratomas having origin from the sympathetic nervous tissue. A sympathico-blastoma almost certainly having origin in the right adrenal.

The symptoms of which this patient complained, pains in the legs, distention of the abdomen, secondary anemia, and a continued temperature, together with the positive agglutination test made that of undulant fever the only logical diagnosis at the time. However, as we look back it is obvious that the cause of these symptoms was the adrenal tumor. The positive agglutination test can be explained on an assumption that at some time earlier in his life he had been infected by the germ of undulant fever, probably producing no symptoms severe enough to attract attention.

Blastomas of the adrenal are very rare. A few cases have been reported in the literature and are referred to as neuroblastomas, sympathoblastomas, and sympathic neuroblastomas. They are often called sarcomas but bear about the same relation to sarcoma as a glioma does to a carcinoma. They should be separated from the tumors of the cortical tissue which belong to the adenoma group. The tissue of origin of the cortex is the interrenal tissue, primarily from the same tissue which gives rise to the urinary tract, and the malignant types are known as hypernephromas.

Medullary tissue and sympathetic nerve tissue, all originate from the same embryonic tissue, known as sympathicogonous cells. And the tumors originating from the medulla are of various types, the more undifferentiated types being found more during fetal life and early infancy, and are of the small round cell type.

The more differentiated tumors of large round or spindle cells are referred to as ganglionic tumors or paragangliomas and are seen in older people about the age of forty-five.

These malignant, congenital small round cell types found in children have been known for a long time. Virchow, in 1864, called them gangliomata. Marchand in 1891 described tumors from the sympathetic portion of the adrenal and noted their resemblance to round cell sarcoma. Pepper, in 1901, and Hutchison, in 1907, published series of cases calling them suprarenal sarcoma, and each described a clinical syndrome. Wright in 1910 collected eight cases from the literature and added four of his own and gave them the name neurocytoma or neuroblastoma. Wolbach preferred the name neuroblastoma sympatheticum to Landau's sympathetico-blastoma. The tumor is now described as a malignant neoplasm originating from embryonal pluripotential cells of the sympathetic nervous system. The majority originate from the adrenal medulla but many have been found coming from chromaffin tissue anywhere in the body.

Pepper found that in his cases the metastasis was to the liver and many of the papers written since call such cases the Pepper type. Hutchison's cases metastasised to the skull and as a result of his paper we have the second type of syndrome. Many of the cases reported show metastasis to the orbits, and it was thought that tumors of the left adrenal would affect the left orbit and vice versa. My case had metastasis to the left orbit but the primary was in the right adrenal. One case is reported in which the tumor was found at birth. The doctor was unable to complete a breach delivery because of the size of the fetal abdomen. He did an evisceration and found the adrenal tumor. Other cases are reported up to four years of age. Metastasis to the bones, lymph glands, skull, liver, ribs, vertebra, and to the kidneys, are frequent. Either or both adrenals may be affected. The brain tissue was not involved in any case I read, but either or both orbits were involved in nearly all cases where metastasis took place in the head.

NON-MYXEDEMATOUS HYPOTHYROIDISM*

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Increasing attention is being paid to mild cases of hypothyroidism, as a review of the recent literature reveals. Engelbach[2] called this condition non-myxedematous hypothyroidism and defined it as "hypometabolism in which no non-endocrine or endocrine etiology other than the thyroid is presented."

According to Warfield,[4] Koch called attention to the possibility of minor decreases in thyroid secretion in 1904. He felt that such cases would not present a true myxedema, but was unable to do anything but speculate upon their occurrence. As laboratory measurements of metabolism have been developed and commonly used, the condition anticipated by Koch has been found to be comparatively common. Vis[3] even goes so far as to say that hypothyroidism is "probably the most common of all chronic diseases in Michigan." Reports such as that of Youmans and Riven[7] from Nashville, Tennessee, show that many cases of mild hypothyroidism may be found in non-goitrous regions.

All writers agree upon the multiplicity of symptoms. Easy fatigability and a lack of energy are outstanding. In Watkins'[5] series of fifty patients, 82 per cent complained of loss of energy and initiative. This is an outstanding complaint in the patient's recital; one is often tempted to make the diagnosis of neurasthenia when the general physical examination is completely negative. Constipation is a common difficulty; in Watkins' series 44 per cent listed it. It would seem to be due to lack of tone in the intestinal tract. Generalized headaches are another frequent symptom. The patient's description makes this condition sound very much like a true migraine.

There are no constant physical findings. The weight may be above or below the average or it may be normal for the patient's build. The pulse rate may be slow, normal, or slightly above normal. There may or may not be dryness of the skin. Weiss and King[6] found swelling of the eyelids common and state that it may be the only obvious abnormality found in a routine examination. Before completing the examination it is very important to rule out occult pulmonary tuberculosis by x-rays of the chest.

The diagnosis must rest upon the finding of a lowered metabolic rate. According to Engelbach,[2] the normal range is from minus ten to plus ten. So any rate below minus ten must be looked upon with suspicion. Hypercholesterolemia is a common finding. We may look forward to an eventual simplification of the iodine tolerance test which has recently been reported by Elmer[1] from the University of Lwów, Poland. It is based upon the fact that in hypothyroidism the tissues do not fix the iodine of the blood as they do in euthyroidism or hyperthyroidism. Iodine is injected intravenously and the percentage of iodine eliminated in the urine within six hours is measured. In hypothyroidism the percentage excreted runs from 23 to 40 per cent; in euthyroidism it is from 12 to 20 per cent; while in hyperthyroidism it may be either below 12 per cent or as high as 20 per cent. At the present time it is a time-consuming determination and not suitable for routine clinical use.

In the female, disorders of menstruation are common. They range from amenorrhea to menorrhagia. Increasingly we are inclined to believe that any disorder of menstruation unaccompanied by pelvic pathologic lesions calls for determinations of the basal metabolic rate. In this connection Case 1 is pertinent.

Case 1.—The patient was a small, well nourished, young Jewish girl. Upon her first examination in September, 1931, at the age of seventeen, she was 61.1 inches tall, weighed 109 pounds, skin was slightly dry, thyroid was normal, pulse 80, blood pressure 110/82. The general physical examination was normal. X-rays of the chest were negative. She reported in January of 1932 complaining of amenorrhea since September, of feeling tired and sluggish for the past month, and of having gained 16 pounds since September. Rectal examination showed an infantile uterus, but was otherwise negative. Blood count and urine examinations were negative. Basal metabolic rate done at that time was minus thirteen.

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She was started on small doses of thyroid. In October of 1932 a metabolic rate was minus 25 per cent. Thyroid dosage was increased to three grains daily and basal metabolic rate was then found to be minus three. Various other glandular preparations, including anterior pituitary substance, were given. The patient began to menstruate in May of 1933 and has been fairly regular since that time. She has taken thyroid faithfully, persisting in it because she feels so much better while taking it. At the present time the metabolic rate is kept around zero by two grains daily alternating with three grains daily. Here it is intriguing to speculate as to what, if any, medication restored normal menstrual function. The improvement in energy and well-being on thyroid certainly justified its administration from the clinical standpoint.

Case 2.—This patient showed a similar amenorrhea and lack of energy, but this time in a rather thin person. In September, 1934, she was twenty-two years of age, 64 inches tall, weighed 110 pounds. Pertinent physical findings included a slight growth of hair on the breasts, a dry skin, a pulse of 80, blood pressure 104/64; the thyroid was normal. The uterus was small, otherwise the pelvic examination was negative. X-rays of the chest and skull were negative. She had not menstruated since May of 1934. Basal metabolic rate was minus seventeen. She tolerated three grains of thyroid, which kept the metabolic rate at minus one or two per cent. She began to menstruate in December, 1934, and has been regular since that time. The patient described herself as feeling much "lighter" mentally when taking thyroid. She gained to 120 pounds while on thyroid medication.

Case 3.—This patient was an asthenic young girl, twenty years old, weighing 117 pounds, and 65 inches tall. She had frequent generalized severe headaches, great fatigability, regular menstruation with a profuse flow on the first day. Except for the underweight the general examination was negative, as was the pelvic examination. The pulse rate was usually in the nineties. Repeated x-rays of the chest were negative. X-rays of the skull were negative. The basal metabolic rate was minus twenty-seven. This was brought up to a plus six by two grains of thyroid daily. The patient has much more energy and the headaches have practically ceased.

These cases all illustrate the frequency of fatigability as a symptom of mild hypothyroidism. It is certainly the outstanding complaint and emphasizes the necessity for determining the metabolic rate when fatigue is the presenting difficulty. In our cases there were no consistently helpful physical findings. The pulse rate may be slow, normal, or slightly above normal. Likewise the individual may be thin, fat, or of normal weight. In all these cases, after careful examinations including x-rays have ruled out tuberculosis, a determination of the metabolic rate is indicated. Then thyroid medication, when the metabolic rate is lowered, gives exceedingly satisfactory results. Of course it is often necessary to have repeated metabolic rates before the diagnosis can be established. But the frequency of the condition, especially in young women, completely justifies this procedure.

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Back Strain and Sciatica

Frank R. Ober, Boston, points out that when roentgenograms of the sacro-iliac and lumbosacral joints are presented which show no evidence in this region of any pathologic condition, either congenital or acquired, it would seem difficult to make a positive diagnosis of either sacro-iliac or lumbosacral strain. One is frequently troubled by the fact that there is a negative roentgenogram of a patient whose clinical signs and symptoms are those of extreme irritation in the sacro-iliac or lumbosacral joints. As a result of observation and examination of a number of cases of this type, it has been discovered that the iliotibial band is an exceedingly important factor in the occurrence of lame backs, with or without an associated sciatica. It has been observed in many patients with low back disturbances that the iliotibial band is extremely tight and prominent when the patient is lying on his back, with the knees together, or when he is in the erect position. The band is very rigid, almost bonelike in consistency, when under tension, usually about one-half inch wide, and is raised above the level of the fascia lata, with which it connects anteriorly and posteriorly. Patients who have this contracture complain of the low back pain as a sensation of strain in the lower part of the back in the region of the lumbar and sacral bones or in the sacro-iliac articulations. Severe sciatica is associated quite often with the condition and there also may be pain along the lateral femoral cutaneous nerve and occasionally along the distribution of the femoral nerve. Those who have the double contracture may show sciatic irritation on one side or both sides, or alternating attacks. The author concludes that the contracted fascia lata is a common cause of lame backs and has been unrecognized. If this is so, it would seem, in the presence of normal roentgen studies, that fusion of the sacro-iliac or lumbosacral regions should not be done. When the fascia lata is contracted, it must produce bad posture. Therefore, apparatus designed to hold the abdomen or the back, or exercises given to straighten the back, will be ineffectual against such severe contractures. The treatment of this condition is the relief of the contracture. In those cases in which there is no sciatica or other pain, the low back pain may be relieved by stretching exercises, and in those cases in which there is a severe sciatica, operation is indicated and the method of procedure is given.—*Jour. A. M. A.*

CANCER SURVEY OF MICHIGAN*

Made by
FRANK LESLIE RECTOR, M.D.†

That cancer patients are being admitted to hospitals in late stages of the disease in the majority of cases is emphasized by the high mortality among these patients compared to deaths from all admissions. In the hospitals reporting in this survey, 19.9 per cent of cancer patients died in the hospital while deaths from all admissions were but 5.8 per cent. It is also interesting to note that but 17 per cent of cancer deaths in Michigan in 1933 took place in hospitals.

Table XX gives detailed information on admissions, deaths and autopsies reported by the hospitals of Michigan in this survey. This table indicates that, on the basis of three living cases for each death, not more than 28.6 per cent of cancer patients in Michigan in 1933 received hospital care. Of course, cancer patients are seen in smaller hospitals not included in this survey, but their number is so few that the total number of hospital cases recorded herein would not be affected materially. It would be interesting to know definitely how and where the remaining 71 per cent of these fatal cases were treated. Some are known to drift into the hands of quacks and charlatans who promise, but fail to accomplish, definite cures; others doubtless delay seeking treatment or refuse it until they are hopelessly incurable and die without medical attention. Another group of ambulatory patients is treated in physicians' offices. The determination of methods of treatment or lack of treatment of this group as a whole would prove a worth-while study for the medical profession in Michigan.

Cancer Treatment Facilities in Michigan

Hospitals—At the time this survey was made, fifty of the seventy hospitals listed were fully approved and eight provisionally approved by the American College of Surgeons, and twenty-five were approved for interne training by the American Medical Association.

No hospital in Michigan is devoted exclusively to the treatment of cancer and allied diseases. The Dr. W. J. Seymour Hospital, Eloise, has set aside 200 beds, 100 for each sex, for cancer patients. These are the only beds in Michigan hospitals so designated. All general hospitals of the State accept cancer patients. Many of the smaller institutions see but few such patients, and the only facilities available for cancer therapy in many of them are surgical in character.

These seventy hospitals are located in thirty counties. There were forty-four counties in Michigan without hospitals of twenty-five beds or more at the time this survey was made. Approximately 12 per cent of the population lives in these forty-four counties, 15 per cent of the cancer deaths in 1933 were reported from them, and 10 per cent of the physicians of the State reside in them.

From the distribution of hospitals noted above and from the information in Table XXI, relative to facilities for diagnosis and treatment of malignant disease, it is seen that the development of special tumor services should be confined to those centers in the State where facilities and experienced personnel are found, or where they may be developed.

X-ray Equipment—Eighteen hospitals in Michigan are equipped with x-ray apparatus of 200,000 volts or more, the minimum voltage considered essential by the American College of Surgeons for acceptable cancer therapy, and also recommended by those having the most experience in the use of deep therapy for treatment of malignant disease. In some communities having no deep therapy in the hospital, it is available in the office of local physicians. In other hospitals without deep therapy, patients needing such treatment are referred to institutions where such facilities are available, or to physicians with equipment and training in this form of therapy.

In Harper Hospital, Detroit, there is x-ray equipment of 650,000 volts capacity. This is one of eight super-voltage installations in the United States, the others being in New York (2), Chicago, Lincoln (Nebraska), Seattle, Los Angeles and Pasadena.

*Continued from January, 1936, issue.
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TABLE XXI. CANCER TREATMENT FACILITIES IN CERTAIN MICHIGAN HOSPITALS
1935

	Hospital	City	Bed Capacity	Deep Therapy in Kv.	Mg. Radium Owned by Hospital	Mg. Radium Owned by Physician	Laboratory		Patho'ogist		Out-Patient Department	Teaching Affiliation	Social Service Department	Organized Tumor Service
							Permanent Tissue Sections	Frozen Sections	Physician	Full or Part Time				
	Emma L. Bixby	Adrian	33	No	No	No	No	No	No	..	No	No	No	No
	*James W. Sheldon	Albion	50	No	No	No	No	No	(1)	..	No	No	No	No
X	*St. Joseph's Mercy	Ann Arbor	115	200	No	50	Yes	Yes	Yes	Full	Yes	No	No	No
X	*University	Ann Arbor	1,285	200	360	..	Yes	Yes	Yes	Full	Yes	Yes	Yes	Yes
	Hubbard Memorial	Bad Axe	28	No	No	No	No	No	(2)	..	No	No	No	No
X	*Battle Creek Sanitarium	Battle Creek	1,000	250	425	No	Yes	Yes	Yes	Full	No	No	Yes	No
	*Leila Y. Post Montgomery	Battle Creek	175	250	No	No	Yes	Yes	Yes	Full	No	No	No	No
	*Nichols Memorial	Battle Creek	71	No	No	No	Yes	Yes	Yes	Part	No	No	No	No
	Bay City General	Bay City	25	No	No	152	No	No	(3)	..	No	No	No	No
	Bay City Samaritan	Bay City	45	No	52	100	No	No	(3)	..	No	No	No	No
X	*Mercy	Bay City	145	200	No	152	Yes	Yes	Yes	Full	No	No	Yes	No
	*Mercy	Cadillac	50	No	No	No	No	No	(3)	..	No	No	No	No
	*Charles Godwin Jennings	Detroit	66	No	No	..	No	No	(4)	..	No	No	No	No
	**Delray	Detroit	95	No	No	..	No	No	(5)	..	No	No	No	No
	*East Side General	Detroit	65	No	No	..	No	No	(6)	..	No	No	No	No
X	*Evangelical Deaconess	Detroit	115	No (7)	No	..	No	No	(4)	..	Yes	No	Yes (8)	No
X	*Grace	Detroit	473	220	No	215	Yes	Yes	Yes	Full	Yes	No	Yes	Yes
	*Grosse Pointe Cottage	Detroit	45	No	No	..	No	No	(4)	..	No	No	No	No
	Grosse Pointe	Detroit	35	No	No	..	No	No	(9)	..	No	No	No	No
X	*Harper	Detroit	650	650	450	400	Yes	Yes	Yes	Full	Yes	No	Yes	Yes
X	*Henry Ford	Detroit	560	200	220	..	Yes	Yes	Yes	Full	No	No	Yes	Yes
	*Jefferson Cl. and Diag.	Detroit	60	No	50	..	Yes	Yes	Yes	Part	No	No	No	No
X	*Providence	Detroit	299	200	100	50	Yes	Yes	Yes	Part	No	No	Yes	No
X	*Receiving	Detroit	650	No (10)	No (10)	..	Yes	Yes	Yes	Full	Yes	Yes	Yes	Yes
X	*St. Joseph's Mercy	Detroit	175	No	No	..	Yes	Yes	Yes	Part	Yes	No	Yes	No
X	*St. Mary's	Detroit	257	No	No	50	Yes	Yes	Yes	Part	Yes	Yes	Yes	Yes
	*Woman's	Detroit	220	250	240	..	Yes	Yes	Yes	Full	Yes	No	Yes	Yes
	Lee Memorial	Dowagiac	32	No	No	No	No	No	(1)	..	Yes	No	No	No
X	*Dr. W. J. Seymour	Eloise	700	200	355	No	Yes	Yes	Yes	Full	Yes	Yes	No	Yes
	St. Francis	Escanaba	100	No	No	No	No	No	(2)	..	No	No	No	No
X	*Hurley	Flint	375	220	No	50	Yes	Yes	Yes	Full	No	No	No	No
	*Women's	Flint	40	No	No	50	No	No	(11)	..	No	No	No	No
	*Goodrich General	Goodrich	24	No	No	No	No	No	(2)	..	No	No	No	No
X	*Blodgett	Grand Rapids	132	200	210	105	Yes	Yes	Yes	Full	Yes	No	Yes	No

X *Butterworth	Grand Rapids	224	200	110	105	Yes	Yes	Yes	Full	Yes	No	No	No
City General	Grand Rapids	35	No	No	105	No	No	No (12)	No	No	No	Yes	No
X *St. Mary's	Grand Rapids	218	200	No	105	Yes	Yes	Yes	Part	Yes	No	Yes	No
**St. Francis	Hamtramck	48	No (13)	No	(13)	Yes	No	Yes	Part	No	No	No	No
*St. Joseph	Hancock	65	No	No	No	No	No	(2)	..	No	No	No	No
X *Highland Park General	Highland Park	156	250	No (14)	..	Yes	No	(4)	..	Yes	No	Yes	No
**Holland City	Holland	50	No	No	No	No	No	(14)	..	No	No	No	No
*Grand View	Ironwood	60	No	No	No	No	No	(15)	..	No	No	No	No
*Ishpeming	Ishpeming	44	No	No	No	No	No	(16)	..	Yes	No	Yes	No
X *W. A. Foote Memorial	Jackson	150	No	No	No data	No	No	(2)	..	Yes	No	No	No
*Mercy	Jackson	145	No	No	No data	No	No	(2)	..	No	No	No	No
*Borgess	Kalamazoo	214	No (7)	No	No	Yes	Yes	Yes	Part	No	No	No	No
*Bronson	Kalamazoo	115	No (7)	No	No	Yes	Yes	Yes	Part	No	No	No	No
X *Edw. L. Sparrow	Lansing	145	No	No	150	No	No	No	Part	No	No	No	No
X *St. Lawrence	Lansing	128	No	No	150	No	No	(2)	..	No	No	No	No
**Mercy	Manistee	56	No	No	No	No	No	(14)	..	No	No	No	No
*St. Luke's	Marquette	85	No	No	No	No	No	(2)	..	Yes	No	No	No
St. Mary's	Marquette	65	No	No	No	No	No	(2)	..	No	No	No	No
St. Joseph's	Menominee	50	No	No	No	No	No	(17)	No	No	No	No	No
**Mercy	Monroe	58	No	No	No	No	No	(6)	..	No	No	No	No
*St. Joseph's	Mt. Clemens	100	No	No	No	No	No	(5)	..	No	No	No	No
X *Hackley	Muskegon	108	250	100	10	Yes	Yes	Yes	Full	No	No	No	No
X *Mercy	Muskegon	100	No	No	10	No	No	(2)	..	No	No	No	No
**Pawating	Niles	35	No	No	No	No	No	(18)	..	No	No	No	No
Lockwood	Petoskey	32	No	No	No	No	No	(14)	..	No	No	No	No
Petoskey	Petoskey	40	No	No	No	No	No	(14)	..	No	No	No	No
*St. Joseph's Mercy	Pontiac	175	No	No	No	Yes	Yes	Yes	Full	Yes	No	Yes	No
X *Saginaw General	Saginaw	133	No (19)	No	201	No	No	(20)	..	Yes	No	No	No
*St. Luke's	Saginaw	50	No (19)	No	201	No	No	(20)	..	No	No	No	No
X *St. Mary's	Saginaw	156	200	No	201	No	No	(20)	..	No	No	No	No
*Clinton Memorial	St. Johns	50	No	No	No	No	No	(2)	..	No	No	No	No
*Chippewa Co. War Mem.	S. Ste. Marie	68	No	No	No	No	No	(2)	..	No	No	No	No
**Sturgis Memorial	Sturgis	38	No	No	No	No	No	(2)	..	No	No	No	No
**Three Rivers	Three Rivers	30	No	No	No	No	No	(14)	..	No	No	No	No
James Decker Munson	Traverse City	55	No	No	No	No	No	(2)	..	No	No	No	No
*Wyandotte General	Wyandotte	150	No (13)	No	(13)	Yes	Yes	Yes	Part	Yes	No	Yes	No

X Approved by the American Medical Association for interne training.
*Approved by American College of Surgeons.
**Provisionally approved by the American College of Surgeons.

Radium—The following hospitals reported ownership of radium in the amounts indicated:

	Milligrams
University, Ann Arbor	360
Battle Creek Sanitarium, Battle Creek	425
Bay City Samaritan, Bay City	52
Harper, Detroit	450
Henry Ford, Detroit	220
Jefferson Clinic and Hospital, Detroit	50
Providence Hospital, Detroit	100
Woman's, Detroit	240
Dr. W. J. Seymour, Eloise	355
Blodgett, Grand Rapids	210
Butterworth, Grand Rapids	110
Hackley, Muskegon	100
Total	2,672

In the following cities the indicated amount of radium is owned privately in addition to that owned by hospitals:

	Milligrams
Ann Arbor	50
Bay City	100
Detroit	765
Flint	50
Grand Rapids	105
Lansing	150
Muskegon	10
Saginaw	201
Total	1,431

This gives a known total of 4,103 milligrams of medical radium in the State. There may be other small quantities owned by private physicians, but it is believed they are not large.

It has been estimated by cancer authorities that two grams of radium should be available for each million of the population or for each thousand deaths from the disease. On this basis there should be available an additional 6,000 milligrams or more of radium in Michigan.

Laboratory Facilities.—Twenty-six hospitals reporting in this survey have either full or part-time physician pathologists with equipment for preparing permanent tissue sections. One hospital is served by a non-medical pathologist. Twenty-four of these hospitals also maintain frozen section equipment. Thirty-seven other hospitals routinely send all of their tissues to capable pathologists in Michigan. This leaves but seven hospitals reporting in this survey not submitting all tissues for pathological examination, and three of these report that selected tissues are examined at the request of the physician in charge.

Autopsies.—A wide variation was noted in the number of autopsies performed in hospitals reporting in this survey. Referring to Table XX, it is seen that eleven hospitals reported no autopsies during 1933. The bed capacity of these eleven hospitals was 558, and to them 8,157 patients, of whom 101 were cancer patients, were admitted during 1933. There were 438 deaths among these patients, not one of which came to autopsy. Twenty-four other hospitals had a smaller percentage of autopsies than required by the American Medical Association, 15 per cent, for interne training. The bed capacity of these twenty-four hospitals was 1,778, and among the 27,052 patients, of whom 488 were cancer patients, there were 1,349 deaths, only 112 of whom were autopsied. Combining the two groups of hospitals noted above, in 1933 there were in Michigan thirty-five hospitals of 2,336 bed capacity that admitted 36,209 patients, of whom 589 were cancer patients, and in which occurred 1,787 deaths with but 112 autopsies, an autopsy percentage of 6.3. But fifteen of the 589 cancer deaths in these hospitals were autopsied, a percentage of 2.5.

The highest percentage of autopsies was reported by Grand View Hospital, Ironwood, 63.6 per cent, followed in order by University Hospital, Ann Arbor, with 54 per cent, Henry Ford Hospital, Detroit, with 45 per cent, and the Edw. L. Sparrow and St. Lawrence Hospitals, Lansing, with 42 and 41 per cent, respectively.

Five hospitals reported 100 per cent autopsies on cancer deaths, but these deaths were usually few in number, in no instance being more than five. In general, the percentage of cancer autopsies was higher than all autopsies. The percentage of autopsies in the twenty-five hospitals approved by the American Medical Association for interne training was thirty-one for all deaths and forty-eight for cancer deaths. Of the twenty approved interneship hospitals in the United States with the highest percentage of necropsies in 1933,* none is located in Michigan.

The comparison between the favorable situation regarding examination of surgical tissues and the small percentage of autopsies in many of the largest hospitals of the State having the services of capable pathologists is one of interest and should be of some concern to those institutions offering interne training. Recognizing the autopsy as one of the most valuable methods of interne

*Journal American Medical Association, v. 103, No. 8, p. 580, August 25, 1934.

teaching and realizing that there are in practically all hospitals of the State approved for interne training pathologists capable of making and interpreting autopsies, it would seem desirable that a greater effort be made by these hospitals to obtain a much higher percentage of autopsies than has been reported in this survey.

The usual excuse given for a low necropsy record is the inability to obtain permission of relatives. Such excuses can hardly be considered valid when many other hospitals in widely separated localities report no difficulty in obtaining a high percentage of autopsies.

Out-Patient Service.—Twenty-one hospitals reporting in this survey have organized out-patient departments. These are located in Ann Arbor, Detroit, Dowagiac, Eloise, Grand Rapids, Ishpeming, Jackson, Marquette, Pontiac, Saginaw and Wyandotte. Several other hospitals provide facilities for the return of ambulatory patients for observation or re-treatment, but do not maintain organized dispensaries for general out-patient work. In other communities visited, the medical profession undertakes the care of indigent patients in their offices.

Organized Tumor Service. — Tumor clinics organized in whole or in part in keeping with recommendations of the American College of Surgeons were found actively functioning in the following hospitals:

University, Ann Arbor
Grace, Detroit
Harper, Detroit
Henry Ford, Detroit
Receiving, Detroit
St. Mary's, Detroit
Woman's, Detroit
Dr. W. J. Seymour, Eloise

The organization of similar clinics in other hospitals was being discussed and in a few instances such service was found to have functioned previously, but at the time of the survey was inactive.

Social Service.—Nineteen hospitals cooperating in this survey maintain departments in charge of trained social workers. In smaller communities and in smaller hospitals it was said that physicians were able to keep in touch with their cancer patients by frequent contact with them or with their friends or relatives.

Teaching Affiliations. — Three hospitals are directly affiliated with medical schools for teaching purposes. These hospitals and their affiliated schools are:

University, Ann Arbor, University of Michigan School of Medicine
Receiving, Detroit, Wayne University School of Medicine
Dr. W. J. Seymour, Eloise, Wayne University School of Medicine

State Department of Health.—Until January, 1935, the State Department of Health had not participated actively in any of the cancer programs of the state beyond contributing information on cancer deaths. In January of this year an appropriation from the U. S. Public Health Service was made for the purpose of studying cancer incidence in rural communities. Since that time a physician has been employed by the department on a full-time basis and is devoting his time to studying this problem in those counties and districts of the State having full-time health departments. It is hoped and believed that the information gained by this detailed study will prove of great value in extending knowledge of this problem in rural areas and of methods best suited to its control.

Detroit Department of Health.—In 1927 a Division of Cancer Control of the Bureau of Medical Service of the Detroit Department of Health was organized under the direction of a part-time physician and three full-time nurses. The work of this division centered around the collection of statistics on cancer patients available through hospitals and private practitioners, and on cancer mortality from records of the Health Department. The services of this division were made available without cost to hospitals and physicians of Detroit for obtaining follow-up information on cancer patients. At the same time data of importance were obtained for the records of the division with the hope that in time a collection of data on various aspects of the cancer problem would be available for research purposes.

The work of this division continued until more than 3,000 records had accumulated in its files. Due to the depression it became necessary to reduce the personnel of this division, thereby curtailing its activities to a great extent. Two nurses remained in charge and devoted their time largely to following cases already listed. About two years ago a coöperative program was developed by the Detroit Department of Health and the Wayne County Medical Society whereby the Medical Society made available without cost quarters for housing

the files of the division and its personnel, which at this time consists of a full-time nurse. Her efforts are directed toward obtaining for the files of the division data on hospitalized cancer patients and in following, so far as her resources permit, cases that have been under treatment.

It is hoped that the time will soon come when the work of this division will not only return to the functions it exercised when first organized, but expand to provide a clearing house on all cancer patients in the city of Detroit. Its work has been unique in that Detroit has the only municipal health department in the United States undertaking a definite cancer program. A large amount of valuable data is to be found in the files of this division, and if the follow-up can be maintained, this information will become of unique and lasting value as a source of material for clinical and statistical study.

State Medical Society.—The invitation to the American Society for the Control of Cancer for this survey is in keeping with the interest of the Michigan State Medical Society in the cancer problem. Since 1930 there has been an active cancer committee which has concerned itself with the study of the distribution of facilities for the diagnosis and treatment of cancer, and more recently with educational problems. At the present time it has under way a comprehensive lay educational program in which authoritative articles on various phases of cancer are appearing in the newspapers of the State. A series of educational talks on cancer to high schools and colleges of the State is also being developed.

In coöperation with the postgraduate department of the University of Michigan, a series of short courses for physicians of Michigan has been developed in which the subject of cancer has had a prominent place. Through the State Joint Committee on Public Health Education, the State Medical Society has coöperated with the following organizations in the preparation of news articles on health and medical problems and in answering inquiries on similar subjects from individuals through the State:

Michigan Department of Health
Wayne University College of Medicine
Michigan State Dental Society
Michigan Tuberculosis Association
Michigan State Nurses' Association
Michigan State Conference of Social Work
Wayne County Medical Society Committee on Education
State Department of Public Instruction
Michigan Division of the American Red Cross
Michigan State College
Michigan State Hospital Association

Private Health Agencies.—As noted in the preceding section, private health agencies in Michigan have long been active in health educational work.

The Kellogg Foundation, Battle Creek, is concerned primarily with public health education and health work with children under age sixteen. It has not yet taken official notice of cancer as a health educational problem among younger age groups, but when the program of the cancer committee of the State Medical Society for education of high school and college groups is further developed, it would seem logical and desirable that this Foundation assist in the undertaking.

The American Society for the Control of Cancer several years ago was represented by a state chairman who was active in lay educational campaigns. With the changed policy of the Society regarding the emphasis on lay education, the chairmanship for Michigan lapsed for a period, but there is now an active state chairman who is cooperating fully with the cancer committee of the State Medical Society and of the Wayne County Medical Society in the programs of these two committees.

Cancer Prevention and Control

In the foregoing pages details of cancer facilities and service as found by this survey in Michigan have been set forth. Before discussing a program for prevention and control of cancer in Michigan, it may be well to consider briefly some general problems connected with malignant disease.

General Considerations.—While mortality from heart disease is far greater than from cancer, it is probably true that cancer is the most lethal of all diseases, and untreated kills practically all its victims. It never spontaneously terminates in recovery as do acute and contagious diseases. Unless treated early and adequately, chances of a fatal termination are almost 100 per cent. Authentic reports of spontaneous cessation of malignant growth are so few as to be medical curiosities and, according to Dr. James Ewing,* the number of authentic cures of cancer by means other than sur-

*Causation, Diagnosis, and Treatment of Cancer, p. 85. The Williams and Wilkins Co., Baltimore, 1931.

gery, x-ray, or radium, or a combination of these, is equally rare.

Deaths from cancer are increasing annually. Statisticians may debate whether this increase is relative or actual, but this question is not of so much importance to those interested in prevention and control as is the fact that more people are dying from cancer each year.

Cancer is no respecter of social or economic groups. While it falls with more economically disastrous results on those in the small income class, as does all other incapacitating illness, it is found with equal frequency among the well-to-do.

There is no known specific etiology, although scientific workers in the field believe that chronic or protracted irritation, mechanical, chemical, or thermal, is one of the principal contributing factors. There is no conclusive evidence that heredity plays any important part in causing this disease in humans, neither has environment any influence except in a few instances where occupation has shown a close relationship to cancer. Cancer of the bladder among dye workers, chimney sweeps' cancer, and tar cancer among petroleum workers have all shown a rather close relationship to materials worked with.

It is thus seen that the term "cancer" does not apply to a specific disease entity, but to a large group of pathological conditions with a similar symptomatology and histological appearance occurring in both sexes and in all ages. Undoubtedly there is a diverse etiology for conditions known under this designation.

Studies on the incidence of cancer have shown approximately three living cases per death. As the annual number of cancer deaths closely approximates the number of practicing physicians in the State, there are approximately three living cancer cases annually for each physician. This distribution makes it probable that the average physician will see so few cases during the year that his active interest in this problem is at times difficult to enlist.

The only recognized treatment methods are surgery and irradiation by x-ray and radium either singly or in combination. So far as known, every form of cancer is best treated by these methods. There is no occasion for a physician to use other forms of therapy because one of these methods may not be available locally. Under such conditions the interests of the patient dictate that he should be sent where these facilities are available.

Treatment of cancer along lines recognized as adequate requires special facilities, equipment and training. At this time there are but twelve special cancer hospitals in the United States, the great majority of patients with the disease being treated in general hospitals. As the profession and public become better educated to what constitutes adequate cancer service, special institutions may be developed for these patients. At this time special tumor services are being organized in some of the larger hospitals throughout the country. It remains to be seen whether general hospitals can and will provide necessary facilities and personnel to care for cancer patients in an acceptable manner, or whether additional institutions specially designed for this purpose will come into existence.

In addition to provision for treatment by one or more of the means mentioned, a well rounded cancer program includes complete records of the service rendered and a follow-up system whereby the patient's history is available over a period of years following treatment. These patients should be followed for a minimum of five years, and, if possible, during the remainder of their lives, if worthwhile evaluation of the treatment is expected. All hospital cancer records should be kept open until the death certificate can be filed with them.

Sufficient authentic evidence is now available to show that when treated during early stages, i.e., while the lesion is confined to its original site and without evident metastasis, permanent cure can be effected in a large percentage of cases. If the disease is first seen late in its course, the chance of cure is greatly reduced.

(To be continued in March issue)

President's Page

ETERNAL VIGILANCE AND LIBERTY

IN SPEAKING of the unemployment insurance provisions of the Social Security Act, *Collier's Weekly* comments editorially to the effect that all states may reasonably be expected to devise and establish insurance or pension systems soon. "The collection of taxes by the federal government will stimulate even the most reluctant legislature to some kind of action. People who pay the taxes will insist upon deriving some benefit from their money." And speaking of the freedom which the Act gives to the individual state, the editorial says: "It is free to indulge its fancy. The opportunity for not-too-scrupulous politicians is large and inviting."

The truth is that the federal law does not establish unemployment insurance but creates a tax-supported Trust Fund from which states having unemployment insurance or pension systems may draw. In other words, the federal law virtually compels the state to enact federal-approved legislation. Should it refuse, it pays taxes into the federal fund but receives no benefits.

In its report to President Roosevelt, on January 15, 1935, the Committee on Economic Security, whose recommendations were the foundation of the Social Security Act, made the following summation in its paragraph on health insurance: "The rôle of the Federal Government is conceived to be principally to provide subsidies, grants, or other financial aids or incentives to states which undertake the development of health insurance assistance which meets the federal standards." The precedent of the unemployment insurance machination will be followed. Despite the fact that the employed of the nation do not want health insurance (the laboring group recognizes that it means less wages and more taxes and, therefore, has voted against it) the federal law will coerce the states to enact federal-approved health insurance legislation.

Every physician in Michigan should be alive to the possibility of having health insurance forced upon him. Those who would socialize medicine, the groups and individuals who would radically change medical practice for some new, untried type, are busy trying to accomplish their work and to execute it soon. Every doctor of medicine should heed this warning, and become familiar with the arguments of the other side, as well as those on his own side.

The brochure on socialization of medicine being prepared by the Michigan State Medical Society will be sent to you shortly. Study it thoroughly. See that copies get into the hands of your patients, publicly-minded, influential citizens, and other key laymen. This is a job for each and every practitioner of medicine. It cannot be done by a few. It is up to all physicians.

Grover C. Penberthy

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"Every man owes some of his time to the upbuilding of the profession to which he belongs."
—THEODORE ROOSEVELT.

EDITORIAL

TEACHERS AND DOCTORS

Education is under state control. State control of medicine is now limited to state mental hospitals, state and civic hospitals for indigents and civic hospitals for infectious diseases.

We have made an effort to ascertain the number of unemployed teachers in the state of Michigan, which, at the present writing, we find to be 1,203. In other words, 1,203 teachers are seeking employment and some who otherwise would be in the unemployed class are employed on SERA and other government projects, which we presume are extemporized jobs or positions simply for the sake of giving employment that would not be necessary in normal times. Under state control of medicine, there would be a certain limited number of positions for physicians. If there were more doctors in the state than would be necessary to fill these positions, those not required would belong to the unemployed class. If a person with specialized training for any particular line of work cannot get employment in the work for which he is especially trained, he is in the class of unskilled work. For instance, an unemployed teacher cannot fill the rôle of physician or lawyer or vice versa. Many persons with university degrees are to all intent in the unskilled class when it comes to earning a living.

Socialize medicine, and the physician who may not be successful in getting on the government payroll will find himself in a position that no unskilled worker would envy.

CHARLES GODWIN JENNINGS

Dr. Charles Godwin Jennings is dead, but the spirit and philosophy of his life live on. To evaluate these one must go back to the time he entered into practice in the early eighties, when the character of his life work was in its formative stage, when ability began in reality to assert itself. Life was simple then and the relationship of the physician to his patient was more intimate, and for this very reason a great responsibility rested upon him. He was physician, friend, counselor and oftentimes nurse. The trained nurse, the telephone and the automobile were yet in the making; the hospital as a workshop was hardly known. It was truly the horse and buggy days when travel was slow and often difficult.

It was under these trying conditions that Dr. Jennings became the beloved and trusted physician. Once accepted, the family physician was then only under grave circumstances ever dismissed. He came to know the strength and weakness of every member of the family, sometimes through three and four generations. This acceptance of family responsibility was his strength and his usefulness to the community. The trained nurse, the hospital, the laboratory, the x-ray and all the advances in medicine and surgery that have come to us through the years may have aided the precision of diagnosis and the perfection of treatment, but they have not materially changed the doctor's relationship to his patient.

It was not only in the field of medical practice that Dr. Jennings was preëminent, his keen mind could not lie dormant, so within a few years after graduation we find him in the teacher's chair, engaged in hospital organization, on Boards of Health and in medical society activities, having always in mind the advancement of the medical art.

His philosophy of life—that things are here to be enjoyed—found vent in sport. He was an ardent yachtsman and fisherman and often found time to enjoy these diversions.

With his experience of many years, and his accumulated knowledge, which always kept him abreast of the times, he brought to the consulting room a mind which, though yielding to the advances of the medical, was conservative and respected.

When a man has reached the fulness of years and has lived so usefully and so intensively, his passing is but a fulfillment of the order of nature. What is more appropriate to describe his taking off than the famous epitaph in Samson Agonistes:

> Nothing is here for tears, nothing to wail
> Or knock the breast, no weakness, no contempt,
> Dispraise or blame, nothing but well and fair,
> And what many quiet us in a death so noble.

DIRTY DISHES

We print in this number of the JOURNAL a very timely paper by Dr. C. H. Benning, Director, Royal Oak Health District of Oakland County, on the matter of care or lack of it, of dishes and utensils in suburban or rural eating houses, beer gardens and places provided for public entertainment. The menace, for such he calls it, consists in the fact that many seeking licenses for such places are wholly unfamiliar with the sanitary requirements necessary for safeguarding the health of their patrons. While poor sanitation may prevail to some extent in cities, the fact that they are under the supervision of health departments mitigates the dangers to a large extent.

Dr. Benning refers to the practice of merely rinsing beer glasses, and in some instances even this is not done. The washing of dishes by hand is a practice that should be prohibited and the operation performed by dish-washing machines with water sufficiently hot that sterilization would be effected. He cites an instance in a neighboring state in which forty-one persons were infected with typhoid traced to a waiter, a walking typhoid, who had wiped and stacked dishes after they had been washed. In New York City where food handlers are under more or less regular inspection, out of 1981 foodhandlers, three cases of active tuberculosis and fifteen arrested cases were found; also, thirty-two cases of suspected syphilis and six cases of gonorrhea.

Dr. Benning presents a sanitary code that has been suggested. This code is not unreasonable and it should receive the consideration of every physician in the state. The writer has brought before our readers a subject that should be of paramount interest to every one more especially when we consider that Michigan's good highways and parks and lakes have produced a tourist urge during the spring and summer months. There should be sufficient influence among the profession of the state to get behind the State Board of Health and see that all places of entertainment where food and beverages are served are made safe and all health hazards eliminated.

NECESSITIES AND LUXURIES

"The farm income from the 1935 tobacco crop is estimated to be about $249,351,000, including $11,872,000 estimated rental and benefit payments, as announced by the Agricultural Adjustment Administration. Figures based on the December report of the Crop Reporting Board show that the farm value of the 1935 crop is tentatively placed at $237,479,000, as compared with $107,776,000 for the 1932 crop. The farm value does not include rental and benefit payments.

"It is estimated that the farm value of this year's tobacco crop will be about $13,770,000 above the 1934 crop. Tentative figures indicate that the 1935 production will exceed last year's production by about 238,000,000 pounds."

We have not yet heard of any agitation against the high cost of tobacco or other luxuries. It is a very human trait that luxuries mean more to human beings than what are usually called necessities, such as food or medical care. Herbert Spencer* once made a significant observation which we quote at length.

"It has been truly remarked that, in order of time, decoration precedes dress. Among people who submit to great physical suffering that they may have themselves handsomely tattooed, extremes of temperature are borne with but little attempt at mitigation. Humboldt tells us that an Orinoco Indian, though quite regardless of bodily comfort, will yet labor for a fortnight to purchase pigment wherewith to make himself admired; and that the same woman who would not hesitate to leave her hut without a fragment of clothing on, would not dare to commit such a breach of decorum as to go out unpainted. Voyagers uniformly find that colored beads and trinkets are much more prized by wild tribes than are calicoes or broadcloths. And the anecdotes we have of the ways in which, when shirts and coats are given, they turn them to some ludicrous display, show how completely the idea of ornament predominates over that of use. Nay, there are still more extreme illustrations: witness the fact narrated by Capt. Speke of his African attendants, who strutted about in their goat skin mantles when the weather was fine, but when it was wet, took them off, folded them up, and went about naked, shivering in the rain! Indeed, the facts of aboriginal life seem to indicate that dress is developed out of deco-

*Education—Herbert Spencer.

rations. And when we remember that even among ourselves most think more about the fineness of the fabric then its warmth, and more about the cut than the convenience—when we see that the function is still, in a great measure, subordinated to the appearance—we have further reason for inferring such an origin."

What is said of ornament is equally true of other things not necessary to the maintenance of life. However, agitation will doubtless continue against the alleged high cost of necessities, including medical care, while men and women will continue not to question the high cost of things they can do without.

"SOCIALIZED" LAW

In the December number of the JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY we commented on a paper which recently appeared in *Harpers* magazine, entitled, "The Decline of the Professions," by Harold J. Laski. The article (Laski's paper) has been read and commented upon by a large number of the profession. The attack as we intimated did not include the medical profession alone. Law came in for its share. At a banquet attended by about a thousand New York Lawyers on December 14, the subject of Laski's paper came up, when Mr. William L. Ransom, president of the American Bar Association, took occasion to warn the members of the dangers of a socialized legal profession in a socialized state. Our information is from the *New York Times:*

"Mr. Ransom's warning was based on a recent magazine article by Harold L. Laski, Professor of Political Science at London University, in which it was suggested that all lawyers receive the same pay from the government, and be assigned to clients and cases. Such a proposal, 'excites laughter and seems absurd tonight,' he said, 'but in reality is in full harmony with social philosophies which we hear advocated from high places in the United States today.'

"'It is consistent with some of the steps which have already been taken along the road that leads to the submergence of individual rights and human liberties,' he continued.

"'What is the alternative to that road for the legal profession? Is it merely to let matters drift and muddle along as they are? If the lawyers of the United States do not want government to organize and control the legal profession, the lawyers had better organize and govern it themselves, in the public interest.

"'An independent and self-governing legal profession that cannot be commanded by retainers, cajoled by public office or intimated by threats and charges against lawyers individually or against the profession as a whole is one of the best safeguards of freedom in the United States.'"

KING GEORGE V*

D. S. BRACHMAN, M.D., Detroit

The City of London Red Cross Hospital, unit of the Fifth London General Hospital, which was an ordinary busy military hospital of that time, its beds recently filled with sick and injured from France, underwent a complete change of atmosphere early one morning in the late Summer of 1916 when a telephone message was received from Buckingham Palace—"The King will visit your hospital at 10 A. M. today, and requests that there be no formal reception."

Joy, anticipation, and awe were registered in various degrees among the patients and staff, the latter beginning immediately to practice their courtsies. Nor did this leave me unaffected—the number of questions I found it necessary to ask, such as how one addresses a king, etc., would have filled a book. I was informed by one of the staff that as M.O. i/c (medical officer in charge), I would be accorded the honor of escorting the King about.

A feeling of awe such as I had never experienced before nor since, rapidly enveloped me. At five minutes to ten there appeared about the hospital many men, singly and in pairs. They seemed to be leisurely walking about. We soon realized that Scotland Yard was on the job. Punctually at ten the King's Equerry, Captain Cust, arrived, rapidly looked about and selected a place for the presentation. Immediately following, both the King and Queen appeared, our first intimation that we were to be favored by both Their Majesties.

I have always felt that my face must have betrayed my feelings, for King George, with a very genial smile, shook hands with me and immediately opened discussion. Within two minutes he made me feel entirely at ease, a feeling which lasted during the entire hour and ten minutes that he stayed.

After a few preliminary remarks, the tour of inspection began, with the first visit to a patient who was tagged P.U.O. (pyrexia of unknown origin), a frequent diagnosis at that ime. I shall never forget the patients' joy as the King stopped at every bed. Occasionally King George asked some very technical question. It was apparent that his visits to the hospitals were not duty calls, but that he was deeply interested in the welfare of the patients, his subjects. I recall that the king spent some time at the bedside of an Australian who was badly wounded, asking him friendly questions. I am certain that the psychological effect of the King's thoughtfulness was at least partly responsible for the man's desire to live and was a help to him in his successful battle with death.

On entering the hospital kitchen, a nurse, who was busy at the stove, showed her great embarrassment at being caught unawares and courtsied rather awkwardly. King George apologized for the intrusion and said, "I am very much interested in kitchens. I occasionally do some cooking myself."

Both the King and the Queen again shook hands with me upon leaving the hospital, and though there was a sense of relief in knowing that Their Majesties' visit was completed without any untoward incidents, it is impossible to express the inward joy and satisfaction I felt following this experience.

King George's presence on the throne steadied the

*Dr. D. S. Brachman of Detroit served as medical officer in charge of the London Red Cross Hospital from July, 1916, to July, 1918. The hospital is located in the city of London which occupies an area of one square mile which includes the Tower, the Bank of England, the Mansion House, St. Pauls, et cetera. Dr. Brachman lived in London ten years in all, eight years following the Armistice. He has kindly contributed this brief close-up of the late King at our request.—*Ed.*

people through many adversities. There was simple cheer in his quiet smile. He represented the whole people and the interests of the nation. One must add here that the solid qualities of the English people helped make King George the beloved monarch he was, just as he, by his sterling qualities, led his subjects through critical times.

With heavy hearts the nation moves on. An invisible force compels one to join Britain in—"The King is dead. Long Live The King."

Modern Concepts of Roentgen Therapy in Cancer

W. Edward Chamberlain, Philadelphia (*Journal A. M. A.*, Dec. 7, 1935), tabulates the history of roentgen therapy in cancer from the beginning (1896) down to the present day. In spite of a better knowledge of the limitations of the methods, roentgen therapy is being used more extensively today than at any previous time. This fact alone is sufficient evidence that the method has proved merit, for the present vogue is based not on superstition or wishful thinking but on sound knowledge and proved fact. Improvements in apparatus, while immensely valuable, have had small part in promoting this increasing use of irradiation. The important advances have been in the knowledge of how best to divide the dose, how best to preserve the integrity of the normal tissues, and how large a total dose to administer in a given case. These are the advances that deserve attention. That preoperative irradiation is still in its experimental stages, few will deny. Perhaps it is still too soon to include it as one of the important advances in the present state of our knowledge. Nevertheless, the method is growing rapidly in favor of the surgeon and there is evidence that its use is beginning to rest on a scientific basis. The routine employment of postoperative irradiation has always rested on unscientific thinking. To the thinking radiologist it has often seemed that since radiologic cure rests on tumor cell sensitivity and tissue response to irradiation rather than on the numerical count of tumor cells, the radiologist who can "take care of the residual tumor cells" after a surgical operation might have taken equally good care of the entire tumor, especially in view of the fact that his aim is better and his therapy less hindered when he is treating a tangible tumor, not an intangible ghost. The author is not advocating the complete scuttling of all forms of postoperative irradiation in every case. Neither is he advocating the abandonment of surgery in favor of irradiation in carcinoma. He does feel, however, that the decreasing emphasis on routine postoperative irradiation is evidence of progress, toward the substitution of correct thinking for poorly founded superstition. Under unsolved problems for the future he discusses two questions: 1. Will the use of higher voltages and thicker filters (i.e., shorter wavelengths) increase the percentage of five-year cures? 2. Can surgery prevent the late recurrences of tumors that have apparently completely regressed? Today the radiologist and the surgeon stand face to face, each in need of the other's help, each ready to do his proper share of the work of combating cancer. The radiologist is just as anxious to avoid taking human life by depriving a patient of the benefits of properly indicated surgery as the surgeon is anxious to avoid the futile mutilation of a patient who might better be treated by irradiation. Their brotherhood is made more complete by their common knowledge that neither has the final answer to the cancer problem: that real coöperation between physician, surgeon, pathologist and radiologist constitutes the best armamentarium in the present-day battle with cancer.

BE PREPARED FOR YOUR CANCER PATIENT

CARCINOMA OF THE GASTRO-INTESTINAL TRACT*

By means of an educational campaign that is now being carried out by the Cancer Committee of the Michigan State Medical Society, the layman is being familiarized with the early symptoms and signs—the danger signals—of cancer, so that he may be prompted to report them early. If the patient is thus aroused it means that we as physicians must coördinate in our minds better than ever the early symptoms and signs in order that we may be ready to meet the demand that we hope is coming. As a matter of fact, each of us should be a leader in this fight against cancer, rather than be content to follow or fall in line.

Cancer of the gastro-intestinal tract ranks with the most frequent types of cancer.

Stomach

Cancer of the stomach constitutes in the neighborhood of 15% of all cancers. It is more common in men than in women, for the same reason, probably, that there is more cancer of the skin and of the mouth in men. It is generally recognized that chronic irritation of one kind or another is the exciting cause of cancer in most instances. The skin, in the case of men, is subjected to more irritation by reason of their habits and occupations. They are less mindful of oral hygiene, hence their tissues are subjected to more chronic irritation of these parts, and consequently more cancer. While it has not been proved that chronic irritation causes cancer of the stomach, there is, nevertheless, no good reason to assume that the mucosa of the stomach should react differently to irritation than other tissues. The stomach is probably the most abused organ of any, and in this respect men are greater offenders than women. Everything is "dumped" into it—hot foods and drinks, coarse foods, poorly masticated foods, alcohol to excess, and, in addition to this, infection carried from an unclean mouth.

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*This is the third contribution sponsored by the Cancer Committee of the Michigan State Medical Society.

The early symptoms of cancer of the stomach are notoriously vague, indeterminate and misleading, and because of this the patient too often considers them as "dyspepsia" and consequently no heed is given them. To the physician the early clinical history and physical findings of cancer of the stomach will not allow him to differentiate it from functional disturbances, a polyp, an ulcer, a gallbladder, or possibly an appendix. He should never fail to think of cancer in a patient of 35 years, or over, suffering from any form of indigestion that tends to persist, especially so if he has always had good digestion. In the case of any suspicion a searching investigation must be made. It is to include the family history (for cancer), present illness, physical examination, gastric meal, stool, blood and x-ray examinations. If evidence of stomach pathology is found it becomes necessary to differentiate between a gastric ulcer and cancer. As a rule symptoms relieved by food or alkalies, acid regurgitation, high HCl content, x-ray findings of an out-pocketing defect in contrast to a filling defect, point ordinarily to the diagnosis of ulcer and away from cancer. If doubt exists, a three weeks' course of conservative ulcer treatment is recommended with repetition of the roentgen gastric study at the end of this period. In the case of ulcer there should be complete relief from all symptoms and improvement should be demonstrable by the x-ray study. If unrelieved and unimproved, an exploratory operation should be done.

A "typical case" runs something like this: Loss of appetite, distaste for meat, loss of weight, strength or both, anemia, pain, regurgitation, vomiting, obstruction, signs of visible waves, a palpable tumor mass.

Various combinations of the above symptoms and signs may go to make up a typical case, but by the time one has become "typical" it is too late to cure.

Small Intestine

Cancer of the small intestine is rare. The symptoms are usually those of partial obstruction, recurring attacks, and intestinal disorders that have not existed before.

Large Intestine

Cancer of the large intestine is about as common as that of the stomach, but it has a relatively low degree of malignancy. The location of cancer at points of normal constriction and sacculation favoring stasis, suggest the influence of irritating intestinal contents in their formation. The order of frequency is as follows: rectum, sigmoid, cecum, the flexures, the transverse and descending colon. Clinically, cancer of the large bowel can be divided into that of the cecum, the intervening colon and the rectum.

The clinical behavior will depend a good deal upon the location of the growth, as, for example, in the cecum, where the fecal content is liquid, there will naturally be few obstructive symptoms. There may, however, be some change in the bowel function.

In the distal colon (the storage segment) excluding the rectum, the solid character of its contents facilitate obstruction. The usual symptoms are beginning constipation, or increased constipation, later distention by gas, with occasional attacks of cramp-like pain gradually becoming more frequent and culminating finally in some cases in acute obstruction.

Cancer of the rectum, anus and recto-sigmoid constitute about 12 per cent of all cancers in the body and about 80 per cent of intestinal cancers. The frequency of cancer in this region lays a great responsibility upon the physician to investigate carefully all cases presenting any symptoms referable to the intestine or rectum. The rectum is a comparatively silent area and cancer usually causes little distress during the first six months. However, during this period there may be trivial but definite symptoms such as slight irritation or change in the character or frequency of the bowel movement. Later comes tenesmus and urgent desire to defecate, a feeling of fulness in the rectum not relieved by defecation, foul stools, the passage of mucous or blood without feces. These are usually the late signs—the "typical case." At this stage it is oftentimes too far gone to be able to effect a cure.

The diagnosis of cancer of the rectum and recto-sigmoid is readily made by proper digital and sigmoidoscopic examination. It cannot be made by laboratory examination of the stools, and rarely by barium enema. It is a common mistake to rely on the x-ray to rule out rectal cancers (this applies to some extent to cancer of the stomach and intestine).

If hemorrhoids, which are bleeding or might bleed, have been found, the physician cannot be absolved from blame if he does

not investigate higher up to make sure that there is no other lesion from which the blood is coming.

In all general examinations, and certainly in every patient who comes to the physician for any type of rectal trouble, the patient should have the benefit of routine digital and sigmoidoscopic examination. These are just as important as nose, throat or vaginal examinations. If a growth is present a biopsy specimen should be obtained. If the report is negative for cancer, and the lesion appears to be malignant, a second specimen should be taken.

Summary

Stomach.—Any person, thirty-five years of age, or over, suffering from any form of indigestion, especially so if he has always had good digestion, should be studied completely as outlined above. A gastric lesion unrelieved by adequate diet and rest should have the benefit of an exploratory operation. Surgery is at present the only treatment for cancer of the stomach. The percentage of five year cures is approximately 20 per cent. A better percentage of cures must come from earlier report by the patient and earlier diagnosis by the physician.

Intestine.—Any change in the bowel habit, or any unusual sensation reported, should cause the physician to suspect cancer. Bleeding means cancer until ruled out.

The physician cannot be held responsible for late diagnosis in patients who have failed to consult him until late in the course of the disease, but it is a sad indictment when months are allowed to pass, after the patient has consulted a physician, before a proper diagnosis is made.

Analysis of Apparent Increase In Heart Diseases

Alfred E. Cohn, New York (*Journal A. M. A.*, Nov. 2, 1935), demonstrates, by a set of curves, the net increase in circulatory diseases after the age of 60. The figures given describe the condition in the United States registration area of 1900. They may be representative of the country as a whole, but, seeing how closely diseases of all sorts are dependent on the environment, the climate in the West and South may actually require a different description of the course of cardiac disease for these states. Beginning with the age of 40 there has been a rise in the death rate from chronic cardiac diseases, decade by decade, from 1900 to 1930. From his study the author infers that there has been a rise, but only a slight one, in the death rate from circulatory diseases. The rise is due apparently to savings from deaths resulting from infectious diseases in the very decades in which the slight rise in the circulatory disease has occurred.

A MOMENT OF MEDICAL HISTORY

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TRANSFUSION

From early times, blood was thought to be endowed with certain life-giving qualities. Even now, in popular speech, there is an expression "The blood is the life." Blood is likewise characterized as good or bad and a particularly virile individual is spoken of as red-blooded. Such folk beliefs were adapted twenty-four centuries ago by Empedocles of Acragas in his view that the blood was the seat of the innate heat of the body. The pneuma, that subtle force basic to life, was thought to reside in the blood. This doctrine as elaborated by Erasistrates, by Galen and by medieval scholars became a fundamental part of physiological thought till the seventeenth century. It is not surprising then to find blood used in former days as a therapeutic agent, either as draughts or by transfusion, particularly as a method of reviving debilitated persons.

There are allusions to the practice of transfusion among the ancient Egyptians, Greeks and Romans. A custom which was apparently transfusion was referred to in the Wisdom Book of Tanaquila, the wife of Tarquin the Ancient. The sacred books of the priests of Apollo mentioned the operation. Reference to the practice was likewise made in an anatomical work by Herophilus. Pliny and Celsus condemned the practice. The allusions in these old works were vague and are frequently hard to interpret. For instance, an old Hebrew manuscript stated that "Naam, leader of the armies of Ben-Adad, king of Syria, afflicted with leprosy, consulted physicians who, in order to cure him, drew out the blood from his veins and put in that of another." Similarly, in Ovid's Metamorphosis, we are told that

> Seizing a blade, Medea,
> A vein in the aged throat severed
> And withdrawing the blood of old age
> In its place poured a life giving fluid.

Nothing of the method or efficacy of the treatment is apparent. In many references, a draught of blood rather than transfusion

might have been implied. In 1492, unsuccessful attempts were apparently made to prolong the life of the aged Pope Innocent VIII by means of transfusion. The blood of the old man was passed into the veins of three youths whose blood was in turn transferred to the veins of the pontiff. It was recorded that the three boys died, presumably from air getting into their veins. Again, the reports of this incident are vague and at variance with one another. It is difficult to reconcile the practice of transfusion with the concepts on blood formation and movement that were prevalent among the old physicians. Implications as to the practice are so common in spite of their vagueness, however, that transfusion could not have been unknown. In the early seventeenth century, several authors mentioned transfusion. Magnus Pegel commented on it in 1604. Another account of transfusion appeared in the writings of Andreas Libavius in 1615, but it is not known whether this is a description of an actual practice or a satirical comment on attempts at rejuvenation of the aged by charlatans. In 1628, Giovanni Colle of Padua discussed the effects of diet and drugs in prolonging life. He mentioned transfusion as a therapeutic aid and further suggested that medicaments might be added to the blood.

In the same year, 1628, Harvey's monumental work on the circulation of blood appeared. The humoral physiology of earlier centuries was incompatible with the circulatory mechanisms which were demonstrated. Blood took on a new importance. Scarcely two decades passed before the idea of transfusion again appeared, this time with widespread confidence that it was based on rational and proven concepts. Francesco Folli in 1652 discussed "the favorable and unfavorable opinions as to the transfusion of blood" and indicated his intention of performing a blood transfusion. During the next few years, a number of men proposed or executed experiments of significance to the history of transfusion.

Christopher Wren, the architect, experimented with animals probably as early as 1656. He ligated the veins of a living dog, opened them on the side of the ligature nearest the heart and with slender syringes or quills fastened to bladders injected substances. The injection of wine or ale into the blood stream of a dog made the animal drunk. It was suggested that the injection method could be adapted to medicinal uses. Timothy Clarke, Robert Boyle and Nathaniel Henshaw undertook experiments which, however, were not overly successful. Johann Wepfer was said to have injected air into the vessels of an ox, a procedure followed by the immediate death of the animal. This effect was later confirmed by Redi on dogs, foxes and a hare. Johann Siegesmund Elsholz, in 1665, injected medicines into the veins of men and dogs. Blood was likewise injected. John Daniel Major also carried on experiments.

Richard Lower made the first extensive experiments and was the first to give a complete and detailed account (1667) of the technic of blood transfusion. He devised a silver cannula for insertion into the donor's artery and a second cannula of bone to be placed in the recipient's vein. In the actual technic of Lower's artery to vein transfusion, the two cannulæ were connected by a tube consisting of an excised blood vessel such as the vertebral artery of a horse. About a decade earlier in France, a Benedictine monk, Robert des Gabels, discussed the possibility of transfusing blood from a healthy man or animal to an enfeebled or diseased person. He devised instruments consisting of two small silver tubes joined by a small leather bulb. The tubes were provided with valves so that pressure on the bulb closed the valves and allowed the quantity of blood to be measured. An operation appears to have been performed in 1658.

Transfusion as performed at this time resulted in the death of the donor animal. Jean Denys (1667) succeeded in preserving the life of the donor and developed the technic so that it was practical for a human subject. At this time, he made a successful transfusion into a human patient. Numerous transfusion experiments were made by such men as Edmund King, Thomas Coxe, Mauritz Hoffman, Cassini and Griffoni. From 1667 to 1670, the French Academy sponsored many studies on supposed rejuvenescence through transfusion. Then a reaction appeared.

A high percentage of transfusions, as might be expected, was unsuccessful, and many of the experiments were without real purpose. The efficacy of the procedure and its rationale were questioned. There was a popular repugnance to that type of trans-

fusion involving animal donors. Even the surgeon, Laury, pointed out that animal instincts or features would be transmitted by transfusion. The Paris Faculté de Médicin was instrumental in passing an ordinance in France which forbid transfusion without the approbation of a doctor of the Faculté. Transfusion thus discouraged became a neglected procedure.

For the next hundred and fifty years, only a handful of physicians advocated transfusion. In Germany, during the 1680's, transfusion was recommended for the cure of leprosy, fevers, scurvy and hydrocephalus. Nuck, in 1714, believed that transfusion was important in restoring blood after hemorrhage, and, in 1749, Cantwell advocated the operation in extreme emergencies. Michel Rosa of Modena performed a few experiments in 1783 from which he concluded that the blood of two species could be mixed without danger to life. Also, an exsanguinated animal could be reanimated if blood from another type of animal were introduced. Harwood (1792) likewise demonstrated the reanimation of an exsanguinated animal by transfusion. A monograph on transfusion appeared in 1802 by the Danish physician, Scheel. It was not, however, until 1818 when James Blundell published his first transfusion studies that a revival of interest in transfusion occurred.

One of Blundell's patients had died of uterine hemorrhage and it seemed that she would have survived had transfusion been available. Blundell began experiments on dogs to determine a satisfactory technic of transfusion. He opened an artery and allowed blood to escape into an open vessel. This blood was sucked into a syringe and injected into the recipient's veins immediately, only thirty seconds elapsing while the blood was out of the circulation of either the donor or recipient. Further studies were made of delayed injections of blood, and it was emphasized that the greatest speed was essential. Blundell questioned the advisability of using blood from another species. He pointed out that human donors were always easily available and that with the syringe method transfusion could be completed easily and quickly.

In the early years of the nineteenth century, serious attempts were made to discover the reasons for the high percentage of unsuccessful transfusions. Prévost and Dumas (1821) suggested that the failure in transfusion was due to mechanical blockage of the capillaries by foreign corpuscles. Since lamb's blood had smaller corpuscles than that of other commonly used donor animals, it was considered best for transfusion purposes. In 1828, Dieffenbach studied both the syringe method and the direct artery to vein method of transfusion. He recommended defibrination of blood to prevent coagulation. Bischoff about ten years later made studies on transfusion between various animals (human, mammal, bird, frog, fish and crab) and came to the conclusion that the lethal effects occurring in transfusion were not due to the mechanical blockage of capillaries by corpuscles, but were due to the presence of fibrin in the transfused blood. Magendie (1838), however, noted that a blood filtrate free from fibrin frequently caused symptoms of distress.

Toward the middle of the nineteenth century, transfusion became a point of intense controversy; some considered it a panacea for all diseases while others denounced the practice bitterly. Both direct and indirect transfusion were in common practice and donor blood was taken from humans, sheep and dogs. The chills, fever, dyspnea and passage of blood pigment in the urine which were commonly observed came to be regarded as increasingly significant symptoms.

Oré recommended that the blood of lower animals be avoided in human transfusion, and Landois in 1875 showed that animal serum hemolyzed human blood. Armin Kohler (1877), using guinea pigs, showed that similar blood killed animals in the same way that dissimilar blood did. As a consequence, saline solutions and milk were often injected as a substitute for blood transfusion. Toward the end of the century, it was commonly recognized that about half the transfusions were unsuccessful and the method was primarily one to be used only as a last resort in severe hemorrhage or in the treatment of cholera.

Shattock (1899) studied the rouleaux formation and clumping of corpuscles in the cat, horse and human, and in mixtures of blood from these forms. By comparing his results with studies available on bacterial agglutination, he turned his attention to diseased human blood. He found that blood from afflicted patients when mixed with normal blood caused clumping in certain dis-

eases, but not in others. Shattock, misinterpreting his data, believed that diseases modified blood in such a way as to cause clumping. The true solution came in a masterly publication by Landsteiner (1901), who experimented with the sera from twenty-two normal persons. Corpuscles of one person and serum from another were mixed in hanging drop preparation, and this was examined for clumping of corpuscles. He found that his series of twenty-two sera could be grouped according to their clumping reactions into three types which he termed A, B and C.

The explanation for the severe and fatal reaction in transfusion was thus apparent. If similar types of blood were transfused, no deleterious effects should appear, while the mixing of incompatible blood of dissimilar type should result in adverse symptoms. This was found to be true in practice.

In 1907, Jansky found that there were four blood groups instead of three, and Moss in 1910 came to the same conclusion. Jansky's grouping I, II, III and IV, the first three types being equivalent to Landsteiner's C, A and B, was unfortunately not given the same symbols by Moss. His type I was Jansky's IV and vice versa. To avoid confusion, a committee headed by Hektoen in 1921 recommended that, because of priority, Jansky's classification be universally adopted. Another classification by Hirszfeld substituted the letters O, A, B and AB for Jansky's numbers, O being a universal donor and AB a universal recipient. More recently, the classification has been somewhat amplified.

While the factors of danger in mixing blood were being analyzed, another field developed to a point where it had an extensive influence on modern transfusion. This field was blood vessel surgery. In the days before antiseptic and aseptic surgery, nothing could be done for a cut or injured blood vessel beyond ligation. An inaugural dissertation by Jassinowsky in 1889 was really the first indication that blood vessels could be sutured without closure of the lumen on healing. Murphy (1897) continued experiments in which it was apparent that blood vessel surgery required the most rigid asepsis, careful handling of vessels, close approximation of the cut edges of vessels, fine sutures and careful suturing technic. The first experiments on circular suture of arteries was performed by Robert Abbe in 1894 and by the end of the century small ivory or magnesium protheses had been introduced by Nitze and Payr for approximating the intimal surfaces of the cut edges of vessels. Numerous studies on methods of experimental suture followed during the first decade of the present century. In 1902, Carrel had performed artero-venous anastomoses. Ullmann in the same year made an experimental transplantation of a kidney. In the next few years, Watts had experimented in vasucular surgery, and Carrel and Guthrie had performed spectacular experiments in transplantation of the thyroid, heart, intestine, kidney and extremities. Through such work, the dangers and difficulties of vascular surgery became known, and an increased confidence arose in vascular surgery.

Crile in 1907 developed a technic of transfusion by connecting the donor's artery to the recipient's vein so that there was a continuous blood vessel passageway for transfused blood. This method together with Crile's extensive experiments on transfusion had a tremendous influence in popularizing the operation. The method, however, had the disadvantage of necessitating the severing of a fairly large artery in the donor and of providing no way of measuring the quantity of blood transfused. After a decade, the method was abandoned in favor of simpler technics.

Klimpton and Brown (1913) introduced a technic in which a specially designed glass cylinder was carefully and smoothly coated on its interior with a thin layer of paraffin. Blood was collected from a donor directly into the cylinder where it could remain up to ten minutes without clotting. The contents of the cylinder could be measured and injected at any desired rate into a vein of the recipient. Lindemann, in the same year, employed a large number of syringes in succession for drawing blood from a donor's vein and rapidly injecting it into a vein of the recipient.

Unger, in 1915, devised a mechanical unit consisting of a syringe provided with a two-way stopcock. A needle inserted into the donor's vein was connected by a tube to the device, which in turn was connected by tubing and a second needle with the recipient's vein. The stopcock was so arranged that it alternately connected the syringe for blood with the donor and one containing

saline with the recipient. Blood was sucked into the syringe from the donor while saline solution flushed the tube connecting the recipient. The valve was turned and blood flowed from the syringe into the recipient while saline perfused the tube connecting the donor. Saline solution prevented stagnation of blood and clotting in the tube which for the moment was not conveying blood to or from the measuring syringe. This effective apparatus has been further modified by Brines (1923) and Feinblatt (1925).

An alternate method of transfusion appeared in 1914. Simultaneously, Huston of Belgium and Agote in Buenos Aires suggested that sodium citrate be added as an anti-coagulent to blood drawn from a donor. Lewisohn, in the next year, studied the anticoagulant and toxic properties of sodium citrate and perfected a technic of transfusion based on the use of this chemical. In the citrate method, blood was allowed to flow into a collecting vessel where it was mixed with .2 per cent of sodium citrate. This treated or altered blood was then allowed to flow by gravity through a tube and needle into the recipient's vein. In 1923, Hartman and Cowles and Antz proposed modifications in which citrate and blood were mixed within the donor's needle.

At present, the syringe method for unmodified blood and the citrate methods vie in popularity, and there are arguments and indications for each method. Both, when efficiently handled, are safe and effective.

Ideal Patients

A medical student was advised by an old doctor to specialize in skin diseases, because:

"The patients of a skin specialist do not call him in the middle of the night nor do they ask him to visit them at their homes. They don't telephone distress messages to the country club, and send telegrams to the football stadium. Finally, they never get well, but also they never die from a skin ailment. They are perfect patients."

Insomnia

A Chinaman opened a laundry on a street between a drug store on one side and a restaurant on the other side. The druggist put up a sign: "We Never Close." Then the restaurant put up a sign which read: "Open At All Hours." The Chinaman, not to be outdone by his neighbors, put up a sign which read: "Me No Sleepee Too."

MEDICO - LEGAL DEPARTMENT

MAY DOCTORS BE COMPELLED TO TESTIFY IN COURT WITHOUT PREARRANGED EXPERT FEE?

By *Herbert V. Barbour*†

So many inquiries have come to me both by letter and when speaking before various county societies as to whether or not a doctor can be compelled to give expert testimony when no arrangement has been made to compensate him as an expert, by proper petition to the court, that I thought a brief article on this subject might be of interest to the profession.

After an exhaustive search in Michigan I have failed to find any decision exactly in point, and from my personal experience, I find that different judges make different rulings.

In one case I recall, the doctor refused to testify unless an arrangement was made for payment of his fee, or to have it guaranteed by the attorney, as he felt that even though the court allowed a fee, plaintiff was not financially responsible and he could not recover even though his fee was taxed as a proper item of costs. A conference was held between counsel for the plaintiff and the doctor, and the doctor refused to divulge the nature of his testimony. Notwithstanding his refusal the court held that before being compelled to answer, if the doctor was asked an expert question, that the attorney had to pay a fee and $25.00 was paid to the doctor and then his testimony was unfavorable to the plaintiff.

In a case that I am presently trying, the Court ruled that a witness called by the plaintiff did not have to answer an expert question propounded by me unless I arranged to pay the witness an expert fee, and this regardless of whether or not the doctor stated he had an opinion on the subject.

Other courts have ruled differently. In a recent case which I tried the doctor refused to testify and appealed to the court on the ground that no arrangement had been made with him in reference to expert fees. Plaintiff's attorney appealed to the

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court to compel an answer and the court ruled that if the doctor had an opinion he was compelled to answer and that he, on proper application, would fix the fee for the expert after the case was decided, and the doctor was compelled, of course, to answer, or be in contempt.

In another case, which I recently tried, a doctor was forced to remain in court most of the day, being brought there by subpoena, and when called he was asked the question as to whether or not the practice followed by defendant was the practice ordinarily followed by the average physician in like and similar localities, and the doctor raised the question of expert fees. The court again held that he was compelled to answer without a fee being paid to him in advance, and then the doctor stated that he did not know the practice of the average physician as he specialized and only knew what he did and not what any other doctor did, and of course the court held that he could not tell what his own practice was, but only the practice of the average physician practicing in his and similar localities. The doctor thus disqualified himself and was excused from further examination.

There is a statute in Michigan relative to expert fees, being Section 14223 of the Compiled Laws of Michigan, 1929, which reads as follows:

> No expert witnesses shall be paid, or receive as compensation in any given case for his services as such, a sum in excess of the ordinary witness fees provided by law, unless the court before whom such witness is to appear, or has appeared, awards a larger sum, which sum may be taxed as a part of the taxable costs in the case. Any such witness who shall directly or indirectly receive a larger amount than such award, and any person who shall pay such witness a larger sum than such award, shall be guilty of contempt of court, and on conviction thereof be punished accordingly.

The following cases furnish some approximation of what courts ordinarily allow for medical testimony.

In the case of *Joy v. Ingham, 204 Mich. 41,* the court made an award of $100.00 a day to each physician who was forced to attend, and the Supreme Court reduced the amount to $50.00 a day.

Unless a showing is made that it is necessary for experts to remain more than one day, the court will not allow compensation for more than one day. *Security Life Ins. Co. v. Schwartz, 221 Mich. 496.*

Other cases indicate that courts should not allow more than $25.00 to $50.00 a day for experts, and we know of one judge in the state who refuses to award more than $10.00 a day to any expert, which, of course, is grossly inadequate.

It would seem from a reading of this statute that an attorney cannot arrange in advance for the expert witness fees to a doctor. Unless the Supreme Court interprets this statute it would seem that a doctor would be more or less at the mercy of the court. For instance, suppose that a doctor refuses to testify and the court compels him to answer with the understanding that a fee will be fixed and taxed against the party not prevailing in the suit, which would mean that the doctor would receive some fee provided the plaintiff or defendant against whom costs were taxed is financially responsible, but he would have no recourse if plaintiff or defendant were not.

It seems to me the doctor is in the position of being compelled to attend court and give valuable time and information without more compensation than the ordinary witness fee. The remedy is not clear but it seems to me that some action might be taken with the Association of Judges and if they concluded it is discretionary with the trial judge, then have a uniform rule providing for the compensation of expert testimony to be deposited with the clerk of the court before a physician is compelled to give his opinion.

Another method to secure a determination would be for a doctor to refuse to testify and then be fined for contempt of court and take an appeal to the Supreme Court and secure an interpretation of the statute to which reference has already been made.

Absence Explained

"I've not seen your 'usband lately, Mrs. Smith. Where is he?"

"'E's 'ad a seizure, Mrs. 'Iggins. 'E'll be away for a month or so."

"I'm sorry to ear that. What sort of a seizure was it?"

"A violent one. Two policemen an' a sergeant."

The Real Boss

Agent—Where's the boss? Is he in?

Proud Father—Yes, he's asleep upstairs in his crib.

Proceedings of The Council of the Michigan State Medical Society

HIGH LIGHTS: Five Year Plan of Michigan State Medical Society Presented; Schedules A, B, C, D Revived as of July 1, 1936; Medical Defense Dues Reduced to One-half Dollar; Secretary, Treasurer, Editor, Executive Secretary, and Medico-Legal Committee Elected; Annual Meeting—Book-Cadillac Hotel, Detroit; Scientific Exhibits Committee Appointed; Budget for 1936 Adopted; Decision Re Contracts to Provide Medical Care to Indigents; Brochure on Sickness Insurance to be Published; Postgraduate Certificates to be Awarded.

THE Council of the Michigan State Medical Society met for its Mid-winter Meeting in the Statler Hotel, Detroit, on January 15-16, 1936, with the following Councilors and Officers presents: Dr. Henry Cook of Flint, chairman, Dr. T. F. Heavenrich of Port Huron, vice chairman, Dr. F. A. Baker of Pontiac, Dr. F. C. Bandy of Sault Ste. Marie, Dr. A. S. Brunk of Detroit, Dr. C. E. Boys of Kalamazoo, Dr. Henry R. Carstens of Detroit, Dr. H. H. Cummings of Ann Arbor, Dr. W. A. Manthei of Lake Linden, Dr. J. E. McIntyre of Lansing, Dr. Vernor M. Moore of Grand Rapids, Dr. Julius Powers of Saginaw, Dr. Frank E. Reeder of Flint, Dr. Thomas P. Treynor of Big Rapids, Dr. Paul R. Urmston of Bay City, Dr. B. H. Van Leuven of Petoskey, and Dr. R. L. Wade of Coldwater; President Grover C. Penberthy of Detroit, President-Elect H. E. Perry of Newberry, Treasurer Wm. A. Hyland of Grand Rapids, Secretary Clifford T. Ekelund of Pontiac, and Editor J. H. Dempster of Detroit. Also present Dr. Angus McLean and Dr. Wm. J. Stapleton, Jr., of Detroit, representing the Medico-Legal Committee; Dr. J. D. Bruce of Ann Arbor, representing the Advisory Committee on Post-Graduate Education; Drs. L. J. Hirschman, H. A. Luce, and J. M. Robb of Detroit; and Executive Secretary Wm. J. Burns. Absent: Dr. Harlan MacMullen of Manistee.

Forty-nine individual items were presented to The Council in three sessions, beginning January 15 at 2:00 P. M. and continuing through two days. Many of the problems were of such a nature that they required reference to a Council Committee which sandwiched in extra work and study between the three busy sessions.

FIRST SESSION OF THE COUNCIL

At the first session of January 15, the following matters among others were considered: Reports from each Councilor on the condition of the profession in his District, the annual reports of the Secretary, the Editor, the Medico-Legal Committee, and the Postgraduate Advisory Committee, and plans of the Section Officers and President for the 1936 Annual Meeting in Detroit.

SECRETARY'S ANNUAL REPORT FOR 1935

I HAVE the honor to present my first report to The Council as Secretary of the Michigan State Medical Society.

Your Secretary is placed in an apologetic position by the circumstance which requires him to cover ten months of the term of office of his predecessor, and two months during which the business affairs of the Society have been conducted under the direction of the Executive Secretary.

During the two and a half months that your Executive and Medical Secretaries have been in office, very little, if any, confusion has arisen because of their geographical separation, although there has been a little delay in one or two minor instances. Our very able Executive Secretary has grasped every opportunity to be of service and has kept pace with the intense activity of the Executive Committee and the several standing and special committees in a way that augurs well for the future of the society. The wisdom of having an Execu- Medical Secretary as the legally responsible agent tive Secretary for the Michigan State Medical Society, and the happy choice of Mr. Burns for that office, have been amply proven. The constitutional stumbling-block which requires that amendments lay over a year before final ratification, leaves the of the office, but what could not be accomplished in principle is being accomplished in fact, thanks to the recommendation given The Council by the House of Delegates.

Total membership for 1935 reached the very satisfactory figure of 3,650. Upwards of 160 of these were admitted during the last two months by the payment of dues for the last quarter, as provided in Section 3 of Chapter 1 of the By-laws. In addition to these, there were two members who paid up arrears for 1933, and twenty for 1934. The total income to the State Society from dues for the year amounted to $30,175.56, exceeding the expectations of the budget by $1,700.00. A membership tabulation is made a portion of this report.

There are 138 unpaid dues, as compared with 175 of a year ago. Eleven counties showed losses in membership totalling 19; 26 showed gains totalling 276, making a net gain for the year of 257, as compared with 233 of last year.

Membership Record

County	1934	1935	Loss	Gain	Unpaid	Deaths
Alpena	15	15	..	..	..	1
Antrim-Charl.-Emmet-Cheboygan	27	31	..	4	1	1
Barry	15	17	..	2	1	..
Bay	64	65	..	1	2	..
Berrien	45	55	..	10	2	..
Branch	16	17	..	1	1	..
Calhoun	109	110	..	1	6	1
Cass	11	11	..	..	1	..
Chippewa-Mackinaw	16	17	..	1	..	..
Clinton	11	13	..	2	..	..
Delta	23	22	1	..	..	..
Dickinson-Iron	19	19	..	..	1	..
Eaton	26	25	1	..	1	..
Genesee	142	155	..	13	..	2
Gogebic	24	25	..	1	..	..
Gd. Trav.-Leela.-Benzie	25	27	..	2	..	..
Gratiot-Isabella-Clare	33	32	1	..	4	..
Hillsdale	21	26	..	5	..	..
Houghton	38	35	3	..	2	..
Huron-Sanilac	26	29	..	3	..	..
Ingham	113	124	..	11	..	1
Ionia-Montcalm	36	35	1	..	1	..
Jackson	73	82	..	9	4	..
Kalamazoo	128	131	..	3	..	..
Kent	216	216	..	..	10	..
Lapeer	14	14	..	..	2	..
Lenawee	34	35	..	1	..	..
Livingston	16	16	..	..	2	..
Luce	9	9	..	..	..	..
Macomb	36	37	..	1	4	..
Manistee	15	15	..	..	..	..
Marquette-Alger	33	33	..	..	1	..
Mason	10	9	1	..	1	..
Mecosta	19	18	1	..	..	..
Menominee	10	10	..	..	..	1
Midland	10	11	..	1	..	1
Monroe	32	34	..	2	2	1
Muskegon	66	69	..	3	..	1
Newaygo	10	12	..	2	..	..
Oakland	98	101	..	3	6	..
Oceana	11	11	..	..	..	1
Otsego-Montm.-Crawford-O-R-O	13	13	..	..	1	..
Ontonagon	5	5	..	..	..	..
Ottawa	32	35	..	3	2	..
Saginaw	93	91	2	..	..	..
Schoolcraft	5	5	..	..	..	..
Shiawassee	29	29	..	..	..	..
St. Clair	44	40	4	..	3	..
St. Joseph	17	15	2	..	1	..
Tuscola	30	30	..	..	..	..
Washtenaw	139	152	..	13	11	2
Wayne	1271	1449	..	178	64	8
Wexford	20	18	2	..	1	..
	3393	3650	19	276	138	21
		3393		19		
Gain for 1935		257		257		

24 other deaths.

The 21 deaths were those who had paid 1935 dues; 24 who had paid 1934 dues, but not 1935 dues, were reported dead, including two honorary members.

Deaths in 1935

It is fitting and proper that we pause at this point in memory of our members who have passed on to their great reward. Our records show that 45 members in 26 county or district societies died during 1935. They are listed as follows:

ALPENA COUNTY
*Dr. John S. Jackson
Alpena, Michigan

BAY COUNTY
*Dr. David T. Smith
Omer, Michigan

BERRIEN COUNTY
Dr. W. T. Bertrand
Coloma, Michigan
Dr. Louis A. King
St. Joseph, Michigan

CALHOUN COUNTY
*Dr. George B. Gesner
Marshall, Michigan

DELTA COUNTY
Dr. David N. Kee
Gladstone, Michigan

GENESEE COUNTY
*Dr. Francis H. Callow
Mt. Morris, Michigan
*Dr. J. G. R. Manwaring
Flint, Michigan

GRAND TRAVERSE-LEELANAU-BENZIE COUNTIES
Dr. Frank Holdsworth
Traverse City, Michigan

GRATIOT-ISABELLA-CLARE COUNTIES
Dr. W. F. Clute
Clare, Michigan

LAPEER COUNTY
Dr. C. M. Braidwood
Imlay City, Michigan

LUCE COUNTY
Dr. Jean B. Christie
Newberry, Michigan

MARQUETTE-ALGER COUNTIES
Dr. L. L. Youngquist
Marquette, Michigan

MASON COUNTY
Dr. E. G. Gray
Ludington, Michigan

MENOMINEE COUNTY
*Dr. Robert A. Walker
Menominee, Michigan

MIDLAND COUNTY
*Dr. Edw. J. Dougher
Midland, Michigan
Dr. C. V. High, Sr.
Midland, Michigan

MONROE COUNTY
*Dr. Philip D. Amadon
Monroe, Michigan
Dr. L. F. Newbern
Monroe, Michigan

MUSKEGON COUNTY
*Dr. Frank B. Marshall
Muskegon, Michigan
†Dr. John Stoddard
Muskegon, Michigan

NORTHERN MICHIGAN
*Dr. William R. Stringham
Cheboygan, Michigan

OAKLAND COUNTY
†Dr. E. A. Christian
Pontiac, Michigan
Dr. James Murphy
Pontiac, Michigan

OCEANA COUNTY
*Dr. W. L. Griffin
Shelby, Michigan

SAGINAW COUNTY
Dr. G. Harry Ferguson
Saginaw, Michigan
Dr. T. L. Ryan
Saginaw, Michigan

SAINT CLAIR COUNTY
Dr. C. H. Ainsworth
Saint Clair, Michigan

SAINT JOSEPH COUNTY
Dr. H. J. Bush
Constantine, Michigan

SHIAWASSEE COUNTY
Dr. Walter S. Bell
Elsie, Michigan

TUSCOLA COUNTY
Dr. W. A. Crooks
Wahjemega, Michigan
*Dr. N. J. Mallow
Gagetown, Michigan

WASHTENAW COUNTY
*Dr. Robert C. Dalby
Ann Arbor, Michigan
*Dr. Chas. F. Unterkircher
Saline, Michigan

WAYNE COUNTY
*Dr. Geo. J. Baker
Detroit, Michigan
*Dr. F. P. Bender
Detroit, Michigan
*Dr. J. W. Cunningham
Detroit, Michigan
*Dr. Mariam N. Fisk
Royal Oak, Michigan
Dr. Edward H. Hayward
Detroit, Michigan
Dr. Ruby D. Hicks
Detroit, Michigan
Dr. H. Edward Knight
Detroit, Michigan
*Dr. Charles F. Kuhn
Detroit, Michigan
*Dr. C. G. Lehman
Detroit, Michigan
*Dr. Chas. W. McColl
Wyandotte, Michigan
*Dr. Isaac L. Polozker
Detroit, Michigan
*Dr. H. R. Varney
Detroit, Michigan

*Members in 1935.
†Honorary members.
Others were members in 1934 but not in 1935.

Financial Status

The fiscal year closed on December 28, and the accompanying statement of the auditors, Ernst & Ernst, depicts the financial status of the society as of that date. Several points of interest are disclosed by this report which deserve especial attention.

1. The auditors find justifiable an increase in the net worth of the Society of $3,359.20, which is largely accounted for by an increase in the quoted market value of the invested funds.

2. One apparent contradiction is the decrease of $482.56 in membership fees as compared with the increase in membership from 3,393 to 3,650. This is accounted for by the fact that in 1934, $6.00 out of the $8.50 from each member remained for Society Activities, after deduction for Medico-Legal Defense and for THE JOURNAL, whereas in 1935 the amount was only $5.50. In 1934 only $1.00 was allocated for Medico-Legal Defense, but in 1935 this figure was restored to $1.50.

3. The business affairs of THE JOURNAL deserve considerable attention. Advertising sales increased by $1,014.31. Since no unusual efforts were made to secure more advertising, this increase is due entirely to the upturn in business. It would seem that this source of revenue might be increased even more toward making THE JOURNAL entirely self-supporting, as is actually the case with a number of other state journals. This will require an increase of more than 50 per cent in advertising revenue.

Based upon the customary allocation of $1.50 from each member's dues, THE JOURNAL showed a profit in 1935 of $1,263.87, as against $1,439.67 in 1934. The cost of printing THE JOURNAL in 1935 was $8,412.36, as against $7,466.28 for 1934. The cost by

months was uniformly higher throughout 1935, with the exception of July and August. This increase is not attributable entirely, or even largely, to the increase in the size of THE JOURNAL, but represents an actual increase in cost of labor and materials.

It is to be noted in the statements of assets and liabilities there is included under assets an item of $1,558.29, which represents the sum paid to the Bruce Publishing Company to liquidate the claim of the Bruce Publishing Company for the unsold copies of the Medical History of Michigan. Your Secretary envisions the prospect of carrying this item on the inventory of the Society for years to come unless some effort is made to dispose of these volumes. It has been recommended that the Rackham Fund be contacted as potential purchasers of copies to be placed in high school libraries throughout the state.

This really excellent work deserves far wider distribution than it has had, and this Council might very advisedly consider making copies available to hospital libraries without charge to such libraries as might make formal request.

Other state societies have found it expedient to give Christmas presents to various state officials and legislators, and have chosen a yearly subscription to "Hygeia" as such a gift. Your Secretary puts the suggestion in the form of a question, which this Council in its wisdom will better judge. Would a gift of this Medical History be appreciated at its full worth by such recipients as have been suggested?

The Medico-Legal Defense Fund

From time to time the suggestion has been made that the $1.50 contributed by each member to the Medico-Legal Defense Fund be discontinued. The House of Delegates and the Council have already taken appropriate action on this suggestion, action which can be shown to be sound by comparison with experience in other states. The simple fact that we have a Medico-Legal Defense Fund unquestionably results in lower insurance premiums for our members. The current rates offered to professional men in Michigan are, as far as one can determine, as low as any in this country, and a good deal lower than some. As a matter of fact, one other state society which has not provided for Medico-Legal Defense in its organization, finds that members practicing in certain localities in that state cannot obtain medico-legal insurance at any price. The mutual contribution of $1.50 from every member of the society does more to cement the local membership in the event of a suit than is readily realized except through actual experience. It is to be noted with gratification that, whereas in 1933 the drain upon this fund was so considerable that it caused a deficit, not only for that year, but for 1934 as well, in 1935 actual disbursements were less by $2,380.74 than the allotment for this purpose from dues. This, plus the increase in the value of invested funds, and interest thereon, brings the total accumulated reserve for Medico-Legal Defense to $15,567.11.

In the Black

The year has ended in the black in spite of the recently increased costs of administration which could not be taken into account when the budget was prepared, and in spite, also, of the payment to the Bruce Publishing Company of $1,558.29.

Annual Meeting

The 1935 annual session constituted an experiment, results of which should prove a valuable guide for years to come. There is perhaps no other community of any size in the entire state that is further removed from more people in the state than is Sault Ste. Marie. The attendance, as anticipated, was small, but whatever lack of numbers there may have been was made up by the quality of the program and the enthusiasm of those in attendance. From the standpoint of attendance an excellent showing was made by the members of the Upper Peninsula. Of a total of 170 members from that portion of the state nearly one-third, or 52, registered at Sault Ste. Marie. Two hundred fifty-four members came from the Lower Peninsula, making a total of 306. Auxiliary members, guests and exhibitors brought the total registration to 444.

At this annual session there were no Section Meetings. The Scientific Assembly met as a single unit. The result was an especially fine scientific program which was enthusiastically received; its quality was at least as high as any ever put on by the Michigan State Medical Society.

In spite of the remoteness of the meeting place there was an excellent scientific exhibit. The Council took recognition of this fact by awarding certificates of merit as expressions of appreciation, as well as in recognition of the excellence of the scientific work done by the exhibitors. This is a splendid precedent, and Section Officers and many others have expressed unstinted approval of the Council's action in providing suitable recognition of scientific endeavor.

Travel expenses were necessarily very great at this meeting and the total cost of the session was not offset by revenue from commercial exhibitors to the extent that may be expected at meetings in large centers of population. The net expense for the annual session in 1935 came to $693.00 as against $21.55 in 1934.

Secretaries' Conference

By authority voted by the Executive Committee at its meeting of November 13, your Secretary has proceeded with plans for an all-day conference for county officers to be held in Lansing on Sunday, January 26. Your Secretary wishes to take this opportunity to express his appreciation for the enthusiasm with which his tentative program has been received. Every speaker approached has offered his hearty coöperation and has accepted the assignment given him. Perhaps the most important place on the program is to be given to a round table discussion to be led by our chairman, Dr. Henry Cook, for the discussion of the two most pressing problems of medical economics. Discussants has been chosen and primed for participation in this round table in the anticipation that county officers in attendance will not use the time to dilate upon their personal experiences and case histories, but will learn precisely how they may be able to evolve working plans in their own counties patterned after successful arrangements already in operation.

In the evening there will be a dinner to be followed by an address by Dr. R. L. Sensenich, of South Bend, Indiana, President of the Indiana Medical Association, a very able speaker and one thoroughly conversant with the economic problems confronting organized medicine. This should prove to be an entertaining and instructive high light of the conference.

Committees

With the accomplishments of the 1935 committees you are already well acquainted. Your Secretary is particularly enthusiastic about the outlook for 1936, and the already considerable accomplishments of the standing and special committees authorized.

The work of the Public Relations Committee, under the vigorous chairmanship of Dr. L. F. Foster, deserves special mention. The gentlemen of this committee have contributed intensely and continuously of their time and energy at great personal sacrifice. They have been away from their prac-

tices frequently, and have travelled long distances over hazardous, icy roads to carry out the responsibility with which they have been charged, namely, the organization of medical filter boards in every county through which commitment of afflicted children is to be effected under the new provisions established by joint resolution with the Probate Judges, Hospital Administrators and the Michigan State Medical Society. This Committee has also evolved a plan for achieving concerted action upon any project through the membership of every county society. The Committee is, in point of fact, an instrumentality through which any program promulgated by any Committee of the State Society and approved by the Executive Committee and the Public Relations Committee, shall be effected and integrated through the entire organized profession in the State.

The Legislative Committee has had monthly meetings and has mapped out a great deal of work for itself. At the present time it is engaged in the study of several specific legislative problems which will be presented in due course.

The Committee on Medical Economics likewise is already organized and working, and has set up for itself a number of important studies, the nature and scope of which will be reported to you in some detail. Its sub-committee on relief medicine has already collected a great deal of data during the past two months, which will be found interesting, if not surprising.

The Preventive Medicine Committee, the Maternal Health Committee, the Cancer Committee, and Special Contact Committee to Government Agencies and Allied Groups have also met and organized themselves with definite programs. It may with confidence be stated that the Michigan State Medical Society has never had greater enthusiasm and wholehearted response from committeemen, and the President of our Society and the Council are to be congratulated upon having selected so fine a group of able men to work out its several problems.

Your Secretary takes this occasion to express his sense of profound responsibility. Having been relieved of the more routine aspects of administration, he has devoted a considerable amount of attention to the more pressing problems which perplex organized medicine in all parts of the country. He has felt it his function to collect and correlate factual material for use by committees and to aid them in programs under consideration. He has recently spent considerable time in the preparation of a brochure setting forth some opinions of organized medicine on the question of state or socialized medical care, and attempting to show that the fruits of medical science may be made available through the improvement in, and correlation among, already existing agencies. This brochure will, of course, not be published until it has been amplified and revised and brought into complete conformity with the point of view of the officers, committees and Council. While it is intended to provide material for students debating the question of State Medicine, it also sets up a goal which has been envisioned by many members of the Michigan State Medical Society as the most logical mechanism to provide better distribution of medical care to people not able to provide it for themselves.

Your Secretary concludes his report with the simple statement that he finds interest and zest in his work and is grateful for the measure of confidence that has been reposed in him by this honorable body.

Dated, January 15, 1936.

CLIFFORD T. EKELUND, M.D., *Secretary.*

ANNUAL REPORT OF CERTIFIED PUBLIC ACCOUNTANTS FOR 1935

WE HAVE made an examination of the balance sheet of the MICHIGAN STATE MEDICAL SOCIETY as at December 28, 1935, and of the statement of income for the fiscal year ended at that date. In connection therewith we examined or tested accounting records of the Society and other supporting evidence, and obtained information from officials and employees of the Society. We also made a general review of the accounting methods and of the operating and income accounts for the year, but we did not make a detailed audit of the transactions.

In addition to our examination of the balance sheet and statement of income, we made certain test checks of the recorded cash transactions and of other data supporting the accounts and records, as hereinafter outlined.

We also reviewed the receipts and disbursements in the funds administered by the Society.

The Society was incorporated as a corporation not for pecuniary profit on September 17, 1910, under the laws of the State of Michigan. It is affiliated with the American Medical Association and charters county medical societies within the State. The purpose of the Society is the federation and protection of the medical profession and the extension of medical knowlege. In the furtherance of these purposes the Society publishes THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY.

Financial Analysis

The balance sheet included herein, in our opinion, fairly presents the position of the Society as of December 28, 1935, on the basis outlined in this report. The following summary shows a comparison of the assets and liabilities at the beginning and end of the year:

ASSETS

	Dec. 28, '35	Dec. 24, '34	Increase
Cash	$ 6,943.90	$ 3,405.80	$3,538.10
Notes and accounts receivable	563.20	781.77	*218.57
Inventory	1,558.29	.....	1,558.29
Securities—at cost, less allowance	24,909.00	20,710.00	4,199.00
	$33,974.39	$24,897.57	$9,076.82

LIABILITIES

Accounts payable	$ 685.73	$ 161.50	$ 524.23
Liability for funds administered	1,038.31	376.30	662.01
Unearned income	1,270.00	1,012.11	257.89
Reserve for Medico-Legal Defense Fund	15,413.24	11,139.75	4,273.49
Net worth	15,567.11	12,207.91	3,359.20
	$33,974.39	$24,897.57	$9,076.82

*Denotes decrease.

Of the increase in the net worth in the amount of $3,359.20, $2,636.25 arises from a reduction in the allowance necessary to reduce the value of securities in the general fund to quoted market values.

Notes receivable for dues represents the uncollected portions of notes taken in settlement of 1931, 1932 and 1933 dues.

Accounts receivable from advertisers and exhibitors were analyzed as to date of charge and are classified in comparison with the balances at December 24, 1934, as follows:

Date of Charge	Dec. 28, 1935 Amount	Per Cent	Dec. 24, 1934 Amount	Per Cent
October, November and December	$568.92	60.04	$ 543.68	53.00
July, August and September	28.50	3.01	43.75	4.16
January to June, inclusive	72.91	7.70	66.75	6.51
Prior to January 1	277.17	29.25	372.55	36.33
TOTAL	$947.50	100.00	$1,026.73	100.00

The balances due from county societies represent dues collected for the Society and subsequently impounded in depositary banks. As the funds are released by the banks, they are forwarded to the Society by the county societies.

Accounts receivable for medical histories sold represent charges made in prior years, with but $5.00 liquidated during the year.

Based upon our analysis of the notes and accounts and conference with the Executive Secretary as to their collectibility, it is our opinion that the allowance in the amount of $650.00 is sufficient to care for losses anticipated at the date of this report. During the year accounts and notes were written off as worthless or compromised in the amount of $143.30.

The inventory represents the cost of approximately 385 sets of the "Medical History of Michigan," a two volume work published by the Society some years ago. During the year the Society purchased the unsold copies remaining in the printer's hands at a price making it possible to sell them at considerably reduced prices.

An exhibit of securities owned is included as a part of this report, which sets forth the par value, cost and quoted market values at December 28, 1935. Unlisted securities have been valued from information furnished by brokers as to the latest bid and sales prices. During the year, no securities were purchased or sold but two changes in securities held were caused through reorganizations. Bonds of the National Gas & Electric Corporation in the amount of $2,400.00 par value were exchanged for 96 shares of $10.00 par value common stock of the same corporation, and 5 per cent bonds of the Associated Gas & Electric Company, due in 1950, were exchanged for 4 per cent income bonds of the same company, due in 1978. Matured coupons on bonds not in default which were not cashed at December 28, 1935, have been included at par value but no other accrued interest is included in the assets.

As far as we could ascertain, provision has been made for all known liabilities at December 28, 1935. We have included herein a statement in summarized form of the receipts and disbursements of the fund administered for the Joint Committee on Public Health Education.

Remittances for 1936 dues have been shown as unearned income and, in our opinion, represent income applicable to the ensuing year, except for that portion which will be credited to the Medico-Legal Defense Fund when it is determined with what share of 1936 dues that fund will be credited.

An analysis of the changes in the Medico-Legal Defense Fund is included as an exhibit herein. The income of this Fund, consisting of $1.50 from each member's annual dues and interest received on bonds allocated to the Fund was $2,835.74 in excess of the amount expended. During the preceding year but $1.00 of each member's annual dues was credited to this Fund.

Surety bonds on the Secretary and Treasurer in the amounts of $10,000.00 and $25,000.00, respectively, were examined by us.

Operations

We have made an examination of the statement of income and expense for the fiscal year ended December 28, 1935, and in connection therewith we examined or tested accounting records of the Society and other supporting evidence, and obtained information and explanations from the Executive Secretary and bookkeeper; we also made a general review of the accounting methods and of the operating and income accounts for the year. The scope of our tests of the detail of transactions during the year are outlined in a later section of this report.

The net income for the year decreased in excess of $5,000.00 due primarily to increased expenses which were incurred as a result of increased activities of the Society. The increase in the income from the JOURNAL was more than offset by increased costs.

Scope of Examination

The scope and nature of our examination and the extent of the tests of the detail transactions are outlined in the following comments:

Cash on deposit was verified by direct correspondence with the depositary bank and reconcilement of the balance reported with the amount shown herein. The certificate of deposit was inspected during the course of our examination. Cash receipts for several months were traced to the deposits shown by the bank statements on file. The recorded cash disbursements for three months selected by us were compared with canceled checks, invoices and other memoranda.

Notes receivable were inspected by us during the course of our examination. Advertisers' and other accounts were found to be in agreement with trial balances of the individual accounts. We did not correspond with any of the debtors to confirm the correctness of the book records.

Securities owned were inspected by us and market quotations were obtained to ascertain their approximate market value at December 28, 1935.

We did not correspond with vendors as a test of the accounts payable.

In addition to the tests heretofore otulined, we tested the amount of dues collected by comparison with the record of membership certificates issued and with other membership records. Interest received was verified by inspection of unclipped coupons. We also reviewed the disbursements made for the account of the Medico-Legal Defense Fund.

In our opinion, based upon our examination, the accompanying balance sheet and statement of income fairly present, on the basis herein outlined, the position of the Society at December 28, 1935, and the results of its operations for the year. Further, it is our opinion that the statement has been prepared in accordance with accepted accounting principles and on a basis consistent with the preceding year, except for the increase in the portion of membership dues allocated to the Medico-Legal Defense Fund.

ERNST & ERNST,
Certified Public Accountants.

January 8, 1936.

BALANCE SHEET
MICHIGAN STATE MEDICAL SOCIETY
DECEMBER 28, 1935

Assets

Cash			
On deposit—Lansing National Bank		$ 2,943.90	
Certificate of deposit—Old Kent Bank—Grand Rapids		4,000.00	
			$ 6,943.90
Notes and Accounts Receivable			
Notes receivable for dues—past due		$ 87.50	
Accounts receivable:			
Advertisers and exhibitors	$ 947.50		
Due from county societies	91.80		
For medical histories	86.40		
		1,125.70	
		$ 1,213.20	
Less allowance for doubtful		650.00	
			563.20
Inventory			
"Medical History of Michigan"			1,558.29
Securities			
Stocks and bonds—at cost	$41,518.75		
Less allowance to reduce to quoted market values	16,734.75		
		$24,784.00	
Uncashed matured coupons on bonds not in default		125.00	
			24,909.00
			$33,974.39

Liabilities

Accounts payable			
For current expenses, etc.		$ 418.01	
Advances for reprints and advertising		267.72	
			$ 685.73
Liability for Funds Administered			
Couzens' Foundation		$ 39.37	
Joint Committee on Public Health Education		998.94	
			1,038.31
Unearned Income			
Dues for the year 1936			1,270.00
Reserve			
For Medico-Legal Defense Fund			15,413.24
Net Worth			
Balance, at December 25, 1934		$12,207.91	
Net gain for the year ended December 28, 1935		722.95	
Reduction in allowance to reduce bonds to quoted market values		2,636.25	
			15,567.11
This balance sheet is subject to the comments in this report.			$33,974.39

INCOME AND EXPENSE
MICHIGAN STATE MEDICAL SOCIETY

	FISCAL YEAR ENDED Dec. 28, 1935	Dec. 24, 1934	INCREASE* DECREASE†
Income			
Membership fees	$19,528.29	$20,010.85	**$ 482.56**
Journal subscriptions	5,477.09	5,172.22	304.87
Advertising sales	8,051.31	7,037.00	1,014.31
Reprint sales	1,687.75	1,689.15	**1.40**
Interest received	932.89	1,146.33	**213.44**
Journal cuts sold	279.46	247.94	31.52
Miscellaneous income	30.30	17.66	12.64
	$35,987.09	$35,321.15	$ 665.94
Expenses (As Shown by Exhibit)			
Administrative and general office	$10,001.68	$ 8,775.14	$ 1,226.54
Society activities	4,541.34	4,114.71	426.63
Committee expenses	6,194.58	3,568.38	2,626.20
Journal expenses	14,383.24	12,706.64	1,676.60
	$35,120.84	$29,164.87	$ 5,955.97
Other Deduction			
Bad accounts charged off and provided for or compromised in settlement thereof.	143.30	238.50	**95.20**
	$35,264.14	$29,403.37	$ 5,860.77
NET INCOME	$ 722.95	$ 5,917.78	**$ 5.194.83**

EXPENSES
MICHIGAN STATE MEDICAL SOCIETY

	FISCAL YEAR ENDED Dec. 28, 1935	Dec. 24, 1934	INCREASE DECREASE
Administrative and General			
Secretary's salary	$ 4,000.00	$ 4,166.00	**$ 166.00**
Executive secretary's salary	1,000.00		1,000.00
Other office salaries	2,506.50	1,723.00	783.50
Office rent	740.00	1,200.00	**460.00**
Printing, stationery and supplies	668.55	409.77	258.78
Postage	231.25	250.00	**18.75**
Auditing	246.38	181.10	65.28
Insurance and fidelity bonds	74.26	136.00	**61.74**
Interest paid		52.08	**52.08**
Furniture and equipment purchased	143.96	282.52	**138.56**
Moving and storage expense	133.67	85.77	47.90
Telephone and telegraph	243.06	202.62	40.44
Unclassified	14.05	86.28	**72.23**
	$10,001.68	$ 8,775.14	$ 1,226.54

*Increase is shown in light face type.
†Decrease is shown in bold face type.

	FISCAL YEAR ENDED Dec. 28, 1935	Dec. 24, 1934	INCREASE DECREASE
Society Activities			
Annual meeting, less income from exhibits	$ 693.00	$ 21.55	$ 671.45
Council expenses	1,621.19	1,922.89	301.70
Delegates to American Medical Association	485.07	257.60	227.47
Secretaries' conference	443.43	608.40	164.97
Traveling expense	812.20	807.21	4.99
Reporting annual meeting	227.01	166.86	60.15
Sundry society expense	259.44	330.20	70.76
	$ 4,541.34	$ 4,114.71	$ 426.63
Committee Expenses			
Legislative committee	$ 3,543.76	$ 1,041.55	$ 2,502.21
Post-Graduate Conference	954.50	1,213.73	259.23
Economics committee	724.23	500.00	224.23
Joint Committee on Public Health Education—donation	500.00	500.00	
Maternal welfare committee	103.80		103.80
Public relations committee	69.60		69.60
Cancer committee	378.85	55.26	323.59
Preventive medicine committee	241.35	255.84	14.49
Radio committee	4.00	2.00	2.00
	$ 6,520.09	$ 3,568.38	$ 2,951.71
Less unexpended portion of donation in prior year to economics committee	325.51		325.51
	$ 6,194.58	$ 3,568.38	$ 2,626.20
Journal Expenses			
Editor's salary	$ 3,000.00	$ 2,250.00	$ 750.00
Editor's expenses		500.00	500.00
Printing	8,525.79	7,316.28	1,209.51
Reprints	1,409.53	1,388.62	20.91
Discount and commission on advertising sales	1,297.92	1,101.74	196.18
Postage	150.00	150.00	
	$14,383.24	$12,706.64	$ 1,676.60
TOTAL	$35,120.84	$29,164.87	$ 5,955.97

RECEIPTS AND DISBURSEMENTS—JOINT COMMITTEE ON PUBLIC HEALTH EDUCATION
MICHIGAN STATE MEDICAL SOCIETY
FISCAL YEAR ENDED DECEMBER 28, 1935

Balance Due Joint Committee—December 25, 1934			$ 11.42
Receipts			
The Detroit News—for articles published		$ 999.96	
Contributions:			
Children's Fund of Michigan	$ 1,500.00		
Michigan State Medical Society	500.00		
Michigan Dental Society	200.00		
Michigan Hospital Association	100.00		
Michigan Tuberculosis Society	50.00		
Wayne University College of Medicine	50.00		
State of Michigan—Department of Health	50.00		
Michigan State Nurses Society	25.00		
		2,475.00	
			3,474.96
			$ 3,486.38
Disbursements			
Salaries:			
Mabel Kelly	$ 1,300.00		
Herman Riecker	975.00		
		$ 2,275.00	
Don E. Lyons		82.00	
Miscellaneous		130.44	
			2,487.44
BALANCE DUE JOINT COMMITTEE—December 28, 1935			$ 998.94

MEDICO-LEGAL DEFENSE FUND
MICHIGAN STATE MEDICAL SOCIETY
FISCAL YEAR ENDED DECEMBER 28, 1935

Balance—December 25, 1935			$11,139.75
Receipts			
Dues from members	$ 5,314.68		
Interest received	455.00		
		$ 5,769.68	
Expenditures			
Douglas, Barbour, Dusenberg & Purdy—legal services	$ 1,902.55		
William J. Stapleton, Jr.—salary	999.96		
Miscellaneous	31.43		
		2,933.94	
			2,835.74
			$13,975.49
Reduction in allowance to reduce securities to quoted market value			1,437.75
BALANCE—December 28, 1935			$15,413.24
Represented by:			
Bonds owned (at approixmate market value)	$ 8,777.75		
Balance, included in assets of the general fund	6,635.49		
TOTAL	$15,413.24		

RECONCILEMENT OF NET WORTH
MICHIGAN STATE MEDICAL SOCIETY
DECEMBER 28, 1935

Net Worth—December 28, 1935—as shown by the Society's books			$13,255.93
Additions			
Reduction in allowance to reduce securities to approximate market value	$ 2,636.25		
Adjustment to take into income, as interest received, value of matured uncashed coupons on bonds not in default	100.00		
		$ 2,736.25	
Deductions			
Unentered liabilities	$ 418.01		
Adjustment of prepaid dues	7.00		
Adjustment of bank account	.06		
		425.07	
			2,311.18
NET WORTH—December 28, 1935—as shown by this report			$15,567.11

THE EDITOR'S REPORT, 1935

IT IS eight years since my appointment as editor of the JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY. This has been an interesting period in my life inasmuch as it has afforded me intimate association with the men in whose hands have been placed the destinies of organized medicine of this state. This period has included two or three of the most prosperous years of medical and surgical practice as well as a veritable "Slough of Despond" from which, let us hope, we are slowly but surely emerging. At the beginning of the period little thought was given by the profession to the social and economic phases of practice. When the doctor feels a reasonable assurance of economic security, he is content to work and to give of his best often without any hope or expectation of remuneration.

Times, however, have changed and this change in attitude has been recorded in the nearly one hundred numbers of this JOURNAL that have come to your desks. An editor can have but little to present in an annual report. Each monthly number of the JOURNAL is his report placed before you in cold type. There have been times when it was necessary to draw in our editorial belt and for financial reasons to curtail the number of pages of the JOURNAL, though we hope there was never any letting down in the quality. The JOURNAL for 1935 contains 812 pages; 108 pages more than 1934 and 127 more than 1933. Probably it is well that the size be not increased. Our editorial endeavor has been to present each month a journal of well selected contents, edited to the best of our ability. You have already observed a variety of features of medical interest indexed for convenient perusal. We have felt that, important as it is to present to our membership papers of the greatest posible merit, it is of equal importance that reading matter be presented in an attractive form. A wholesome and appetizing dinner is even more appealing when presented on an artistically laid out table. The format of the JOURNAL has been as attractive each month as our sense of the fitness of things permitted, and here again the editor is pleased to credit the intelligent coöperation of the printers. The laying out of our literary table has involved many things. The choice of type, headings, arrangement of departments, and, above all, indexing. Proofs in galley form and in page form have been checked and rechecked; as a result, the JOURNAL has been about as clean as it is possible to make it.

Among the special features might be mentioned the Department of the Woman's Auxiliary of the State Medical Society. This brings to the JOURNAL a large number of sympathetic readers and affords physicians' wives a means of intercommunication.

The medico-legal department by Mr. Barbour and his associates presents timely articles from month to month. It is hoped that in the course of a year, most of the legal problems in the minds of our members will be solved. The department "Be Prepared for Your Cancer Patient" will consist of six papers by the cancer committee. It is hoped that those from whom relief is sought will realize the importance of the early apprehension of cancer, and will see that the patient obtains the necessary care without delay. Medical history needs no apology. One cannot know too much of the vicissitudes in the development of the history of his profession.

The custom of referring all copy by the secretary and the executive secretary to the editor makes it possible to avoid duplication.

Regarding the editorials, the writer can say that as much thought and judgment as he is capable of have gone into their composition. Editorial writing demands wide reading if one is to avoid going stale. You are the judges. To get out a journal each month that meets the approval of our members has come to be almost a full time job. The JOURNAL is published by the council. Even when policies are given in broad outline, a great deal must of necessity be left to the editor, particularly in insuring continuity from year to year, for it will be seen that during my tenure of the position eight presidents have come and gone, and three secretaries have served the society during that period.

The editor wishes to thank the publication committee for valuable assistance in the way of passing judgment on editorial matter that involves comment and opinion.

All of which is respectfully submitted,

J. H. DEMPSTER, M.D., *Editor.*

REPORT OF COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION, 1935

MOST of you are familiar with the history of our postgraduate movement in Medicine. About fifty years ago the American profession recognizing the rapid advances of Medicine began the development in certain centers of postgraduate schools. About 1880, the New York Postgraduate School was organized and about the same time a program of postgraduate medicine was instituted at the University of Michigan. The New York Postgraduate School has served a very useful purpose and is still one of the outstanding schools of the country. There are two reasons for this: *First,* it was located in a large clinical center and, *second,* it was organized primarily for this purpose.

In the case of the University of Michigan no one was particularly responsible for the development of the work. Younger men were delegated to teaching positions with the result that after a few years the attendance dwindled and the work was discontinued. About twenty years ago the American Medical Association urged upon the profession the necessity of postgraduate education, and our own State was among the first to undertake its development. This, as some of you will recall, took the form of one and two-day clinics held in the various council districts once a year. This movement proved highly

successful, and marked a milestone in our development in this field.

The rapid advances in Medicine over the past twenty years have made it very difficult for the undergraduate schools to give a satisfactorily rounded course in the four years which even forty-five years ago were thought necessary to teach the fundamentals of Medicine. Thus it became necessary to develop a postgraduate program of teaching, not only for the man who was many years removed from college but in order to amplify the equipment of the more recent graduate.

We soon came to realize that the one- or two-day clinics in each councilor district of the State once or, at most, twice a year were not adequately meeting our needs, and it was with this in mind that the Council of this Society some nine years ago called on our medical schools for direction of this work. Both colleges recognized the importance of the request from the Society and the Detroit College of Medicine felt that it could not undertake the obligation but promised coöperation if the University would undertake the obligation. This the University accepted and I was asked to undertake the development of the new work.

As my time was fully occupied with the Department of Internal Medicine, a year and a half went by before we could satisfactorily fill my place in Medicine and devote my time to the new job. Eight years ago, the Council, at my request, appointed a State Committee to coöperate with me.

Changes have been made in the personnel only on account of death or because of new appointments in the Society. The present members are as follows: Drs. Biddle, Ekelund, Davis, Dempster, Jackson, Marshall, Cook and Slemons, with myself as Chairman. You will note that the Council is represented by its Chairman, Editor and Secretary. Dr. Slemons represents the State Board of Health, Dr. Biddle and Dr. Davis the Detroit College of Medicine, and Dr. Jackson and Dr. Marshall the profession at large.

The Committee has been called together about once a year to consider programs and policies. I have two suggestions with reference to this Committee:

First, as it is a standing committee and one of great importance, the notice of its membership should be included in the listing of standing committees.

Second, I would suggest that Dr. J. Milton Robb, chairman of the Wayne County Committee on Postgraduate Medicine, which collaborates with the State Committee, should be added, and also Dr. B. R. Corbus, for many years associated with this movement. These additions make this a rather large committee but its size insures an added interest on the part of the Society in this important work.

While on this subject may I state that the Wayne County Society has designated a permanent committee to work with me on local programs? It is composed of the presidents of the Society, ex officio: Drs. William M. Donald, David S. Brachman, Charles S. Kennedy, James E. Davis, Alexander Blain, and J. Milton Robb, Chairman. At this time I would like to acknowledge the fine coöperation of the Wayne Committee and the tireless efforts of its chairman in making the local program the success that it has been.

As you recall, we added three extension centers in our teaching program last autumn: Bay City; Traverse City, Manistee, Cadillac, jointly, and a center in the Upper Peninsula. In consultation with the Councilors and various members of the Upper Peninsula Medical Society, it was though best to rotate a continuous program of three or more days through three or four central locations, rather than a daily program over a number of weeks in widespread centers. Our present planning calls for the first program in Marquette during the latter part of May, and in order to develop a better understanding between all our health agencies, consideration is being given to a composite program. This will include a half to one day in which presentations will be made from Medicine, Public Health, Dentistry, and Nursing, and be succeeded by a break-up in the group for a day or two days conference of the individual units.

During our autumn program we had the following registration:

Battle Creek - Kalamazoo	197
Bay City	147
Flint	169
Grand Rapids	234
Traverse City - Cadillac - Manistee	75
Total	822

This is a gain of approximately 100 over last year.

At this time you might be interested in the growth of our work from its beginning.

In 1928-29	47	in attendance
In 1929-30	40	
In 1930-31	133	
In 1931-32	134	
In 1932-33	151	
In 1933-34	310	
In 1934-35	1,245	

The last was the first year of the extension work, the preceding ones being confined to Ann Arbor and Detroit. Of the 1,245 over 700 attended the extension course of 11 days, while 449 attended courses of one week or more in Ann Arbor and Detroit.

May I say in passing without any criticism of the other centers, which all did well, that Bay City had a larger and more constant attendance per population than any of the other centers. Bay City has been fortunate in its Secretary and it has been wise enough to keep him continuously in that position. The efforts of Dr. Urmston and Dr. Foster have succeeded in making a very compact organization.

J. D. Bruce, M.D., *Chairman.*

REPORT OF THE MEDICO-LEGAL COMMITTEE—1935

THE Secretary of the Medico-Legal Committee hereby submits the annual report for the year 1935. Again it is a pleasure to thank the members of the committee for their coöperation. To the Chairman, Dr. Angus McLean, special thanks are due for his great help and wise counsel. We wish that it were possible to give the members of the Society some idea of the time spent by the Chairman and Secretary in personal interviews with physicians desiring help and information. So much of the work is of a confidential nature that it is thought unwise to publish it.

Thanks are also due Mr. Herbert Barbour, our attorney, and Mr. Clayton Purdy of his office for their great help in carrying on the work of the Committee.

The Secretary wishes to call attention to the series of articles running in the Michigan State Medical Journal on medico-legal topics of interest to the doctor. These articles have been prepared by Mr. Barbour and Mr. Purdy and some by your Secretary. These will be continued as a feature of the

Committee's work. Mr. Barbour's report will be included as part of this report.

The thanks of the Committee are also due to Dr. Herbert Dempster, Editor of our fine JOURNAL, for his coöperation.

Thanks are also due to Dr. B. R. Corbus, our former secretary, for his ready response to all our inquiries.

We also want to say a word of appreciation to Dr. W. C. Woodward, of the Medico-Legal Committee of the American Medical Association, for his service in special matters along the line of this Committee's work.

Again, as in years past, we call attention of the profession to the continued menace of malpractice. No one is immune; for example, one of our young graduates, not a member of the Society, not insured, just trying to get a start, was sued for ten thousand dollars by a charity case. The operation was done at a City Hospital, but the lawyers attached to the City Government threw up their hands at the idea of defending a malpractice suit. We asked why the city could not pay a lawyer. Answer, "We have no funds available." Our Mr. Barbour took the case without a fee and won a nonsuit.

Many of these suits are simply blackmail. "A racket with no justification whatsoever." Nevertheless, doctors must be on their guard always. We will not restate our cautions of previous years. They are a matter of record.

We do suggest that doctors acquaint themselves with their rights and liabilities under the law. We suggest the reading of books such as "Courts and Doctors," a good book on medical jurisprudence, and that classic, "Percival's Medical Ethics." Also the articles in the MICHIGAN STATE MEDICAL JOURNAL and the *Journal of the American Medical Association.* Any physician who is interested can write and we will be glad to send a list of helpful books. The law, like medicine, never stands still; new laws are enacted, new decisions are rendered daily in our Supreme Courts. What was the law yesterday may not be the law today. So we of the Medical Profession should seek to keep abreast of the changes, so that we may know the dangers and thus keep from assuming unnecessary obligations. The Medico-Legal Committee is your source for any information you may desire along this line. Remember, "Ignorance of the law is no excuse."

Herewith is attached a summary of the work for the year 1935:

1. New and threatened cases—38.
2. Cases settled during the year—6.
3. List of some of the questions asked.
4. List of various activities of the Secretary:
   Talks on Medico-Legal Subjects were given before the Wayne County Medical Society, Kent County Medical Society.
   First Aid Group at Chevrolet Co., Nurses at St. Joseph's Mercy Hospital, Phi Rho Sigma Medical Fraternity.
   Course of lectures on Medical Jurisprudence and Ethics at Medical Department of Wayne University.
   Establishment of course in Medical Economics in Medical Department of Wayne University. Lectures by Mr. William J. Burns.
   Special Lectures on Medical Jurisprudence at Wayne University by Messrs. Barbour, Purdy and Brown.
   Establishment of courses in Economics and Sociology as part of the work of Pre-Medic students in Wayne University.

Respectfully submitted,

WILLIAM J. STAPLETON, JR., M.D.
Secretary.

IMPORTANT DECISIONS

Reports of Councilors. Among the reports was presented a problem which recently arose in Macomb County; this was fully discussed. Motion of Drs. Heavenrich-McIntyre: With regard to the proposed contract between twelve physicians of Mt. Clemens and the local Board of Supervisors —any contract entered into for providing medical and surgical care to indigent children or adults shall be made by a county medical society and not by any individual or group. Motion carried unanimously.

Medical Care of Afflicted-Crippled Children.—The Council was given a résumé of activities of the Executive Committee of the Council which for the past three months has been working hard for the revival of Schedules A, B, C, and D. A map showing the integration of the "filter system" in seventy-nine of the eighty-three counties of the State was shown. A committee was appointed to draw up recommendations for presentation at the Second Session of The Council, this date, for adoption by The Council and reference to the Michigan Crippled Children Commission. The Committee: Drs. Penberthy, Baker, Cummings, McIntyre, and Moore.

Joint Committee on Public Health Education.—Dr. J. D. Bruce outlined the progress of the Joint Committee and its plans for the future. A field secretary, recently appointed, is doing excellent work and stimulating concentrated work in districts which require this the most.

Postgraduate Certificates. — From the House of Delegates came the recommendation that rules and regulations be made for granting of certificates of attendance at postgraduate conferences arranged jointly by the Michigan State Medical Society and the Postgraduate Department of the University of Michigan. Motion of Dr. Cummings, seconded by several, that the Advisory Committee on Postgraduate Medical Education be requested to draw up recommendations for such rules and regulations as are required for the granting of certificates of attendance, and degrees of proficiency, such recommendations to be approved by the Executive Committee of The Council. Carried unanimously.

Scientific Exhibits Committee Appointed. —The Executive Secretary reported on the progress of the Section Officers in arrang-

ing the scientific program for the Annual Meeting of the Michigan State Medical Society in Detroit, scheduled for September, 1936. The recommendation of the Section Officers that a Scientific Exhibits Committee be appointed was approved on motion of Drs. Heavenrich-McIntyre and carried unanimously.

The Council recessed at 5:20 P. M. to convene again at 8:15 P. M.

SECOND SESSION OF THE COUNCIL

At the Second Session of January 15, the following matters among others were considered: Annual Report of the Treasurer, Attorney Barbour's report on the right of osteopaths to practice medicine, report of the Medical Economics Committee, resolution to the Michigan Crippled Children Commission, emeritus membership for four physicians, and the Five-Year Program of the Michigan State Medical Society.

The Council convened in Second Session in the Statler Hotel at 8:15 P. M. January 15, 1936. Surgeon General Reynolds of the United States Army was introduced and gave an interesting talk about the Medical Reserve Corps, the advantages of a medical ROTC, and the necessity for a larger Medical-Dental Corps in the Army. Colonel Angus McLean and Colonel Penberthy urged The Council to uphold the recommendations of the Surgeon General and thus uphold the Nation. A Special Committee (Drs. Reeder, Carstens, Penberthy) was appointed to draw up resolutions, and recommended the following:

1. The Michigan State Medical Society notes that there has been a large increase in the enlisted force of the Regular Army with no proportionate increase in the Medical and Dental Corps. It is urgently requested that full consideration be given to the need for the proper number of medical and dental officers, for the purpose of maintaining the health standards of the Army.

2. The Society also notes that recent Appropriation Acts for the support of the Army have resulted in the abolition of the Medical Department R.O.T.C. Units which had been established in a number of Class A medical schools of this country and from which graduates had been commissioned in the Medical Reserve Corps, thereby furnishing a large proportion of the yearly increment required in the Reserve Corps. This method of training medical students and thereby providing Medical Reserve Officers has met with the unqualified approval of the medical profession and continuance is necessary for this purpose and to establish and maintain the proper contact between the Medical Service of the Army and the educational centers of this country.

It is urged that the prohibition relative to the Medical Department R.O.T.C. Units heretofore contained in the Appropriation Acts be omitted in the pending legislation.

Motion of Drs. Reeder-Carstens that this Committee report be adopted, and that the Secretary be directed to mail a copy of the above resolution as approved to each member of both Houses of Congress in Washington, D. C., and to Surgeon General Reynolds. Carried unanimously.

Right of Osteopaths to Practice Medicine.—Mr. Herbert V. Barbour, Attorney for the Medico-Legal Committee, reported that he had made an exhaustive research on the question of the right of osteopaths to practice medicine and surgery. He read digest of the laws and his opinion in the matter. Full discussion ensued. The brief was filed for future consideration. County medical societies are to be contacted regarding this matter. The suggestion that a brochure be printed telling the membership what the laws of Michigan are re the practice of medicine, osteopathy, etc., was referred to the Publications Committee with authority to comply with this request, on motion of Drs. Powers-Reeder, and carried unanimously.

Medical Economics Committee Report.—Progress on the survey of the cost of the afflicted-crippled child laws' administration, being conducted by the Subcommittee on Medical Relief, was reported to The Council. The other activities of the Medical Economics Committee were presented, and the report was placed on file.

TREASURER'S ANNUAL REPORT FOR 1935

I HAVE the honor to present to the members of the Michigan State Medical Society my report as Treasurer for the year 1935.

As required by the by-laws of the Society, the usual indemnity bond was filed with the State Secretary.

The following bonds are now in my holding:

GENERAL FUND BONDS

American Telephone & Telegraph Company	5%	$2,000.00
Associated Gas & Electric Company	4	2,000.00
Community Power & Light Company	5	2,000.00
Grand Rapids Affiliated Corporation	5	6,000.00
Herald Square Building Company	6	2,000.00
Lower Broadway Properties, Inc.	6	2,000.00
National Electric Power Company	5	5,000.00
New England Gas & Electric Company	5	1,000.00
Pennsylvania Railroad Company	5	3,000.00
Peoples Light & Power Corporation	5½	1,000.00
United Light & Power Company	5½	2,000.00

MEDICO-LEGAL DEFENSE FUND BONDS

American Telephone & Telegraph Company	5%	$2,000.00
Grand Rapids Affiliated Corporation	5	1,000.00
International Telephone & Telegraph Company	5	2,000.00
New England Gas & Electric Company	5	1,000.00
New York Central Railroad Company	4	2,000.00
Peoples Light & Power Corporation	5½	1,000.00
Public Gas & Coke Company	3	3,000.00

STOCK

National Gas and Electric Corp.—common—96 shares	$ 960.00

Respectfully submitted,

WM. A. HYLAND, M.D., *Treasurer.*

Treasurer Hyland presented his report on the financial condition of the Michigan

State Medical Society, and on the status of the bonds. The Treasurer's recommendation that the Herald Square Bonds be exchanged for the new issue at 3 per cent with a longer maturity date, was accepted, and on motion of Drs. Carstens-McIntyre the Treasurer was authorized to complete this transaction.

SCHEDULES A, B, C, D

Medical Care of Afflicted-Crippled Children.—The Special Committee (Drs. Penberthy, Baker, Cummings, McIntyre, and Moore) appointed at the First Session to draw up recommendations relative to revival of Schedules A, B, C, and D, presented the following resolution, which was adopted and approved by The Council:

Resolution on Afflicted-Crippled Child Acts

The care of the afflicted and crippled child is the responsibility of the State and not of any group in the State.

The responsibility for a high quality of medical care is the responsibility of the medical profession.

The physicians of the state have been allowed but one dollar per case since July 1, 1935, regardless of the amount or kind of service involved. This is considered manifestly unfair.

The Michigan State Medical Society has set up in each county a filter system for the purpose of prevention of unnecessary expense to the State. (A sample plan now in operation in one county is attached.) This should save the State a considerable sum of money while at the same time it will keep the standard of medical care at a high level.

Therefore, be it resolved that the medical profession of the State of Michigan urgently request the Crippled Children Commission to reinstate immediately Schedules A, B, C, D, and a minimum remuneration for medical services rendered under these acts, payment to be deferred if necessary.

Three matters referred by the Crippled Children Commission to the Michigan State Medical Society for its advice were given to this Special Committee for discussion with the Commission at its meeting of January 16, 1936.

Emeritus Membership. — Applications were presented for Drs. A. N. Collins, Angus McLean, A. Thuner of Wayne County and Dr. J. W. Hauxhurst of Bay County. Motion of Drs. Boys-McIntyre that the names of these physicians be nominated by The Council for recommendation to the House of Delegates for Emeritus Membership in the Michigan State Medical Society. Carried unanimously.

THE FIVE-YEAR PROGRAM

The Five-Year Program of the Michigan State Medical Society was presented by President Penberthy, and met the applause of The Council. The following is a brief digest:

1. **High standard of practice with the continued drive to stimulate postgraduate education.**
2. **Need for the proper selection of officers, county and state and delegates to annual meeting.**
3. **Efficient organization for each County Society—executive committee.**
4. **Support to all committee activities by the members of the Society.**
5. **Education of the public, contacting people publicly minded, influential citizens and continue to take an active part in the public activities of the community. Medical information bureau in all County Societies.**
6. **Socialization of medicine—spread knowledge as to what it means and the resulting consequences. Printed material available upon request at the secretary's office.**
7. **Legislation—professional qualifications act and need for a change in the medical practice act. Laws governing care of the afflicted indigent. Laws giving physicians lien priority. A law to combat corporate practice of medicine.**
8. **Develop a working plan in the various counties or units for post-payment rather than prepayment plan in sickness insurance.**
9. **Need for promoting good feeling and coöperation with one another. United front in matters pertaining to medicine.**
10. **Always have in mind the need for demonstrating honesty of purpose in medical activities, this combined with average intelligence and willingness to work should provide security and create no fear in the mind of the profession as regards the future.**

The Council recessed at 11:57 P. M. to reconvene at 10:00 A. M. on January 16, 1936.

THIRD SESSION OF THE COUNCIL

At the Third Session, called to order by Dr. Henry Cook, Chairman, at 10:00 A. M. on January 16, 1936, the minutes of the First and Second Sessions were read and approved. The following matters, among others, were considered: Report of the Publications Committee, Report of the Committee on County Societies, Report of the Finance Committee, Budget for 1936, Report that Schedules A, B, C, and D will be revived as of July 1, 1936, Brochure on Sickness Insurance authorized, Election of the Secretary, Treasurer, Editor, and appointment of an executive secretary, Election of Medico-Legal Committee, Decision on headquarters for 1936 Annual Meeting.

REPORT OF PUBLICATION COMMITTEE

IT IS our pleasure to present the report of the Publication Committee. We think you will agree with us that the publication of the JOURNAL is one of the most important activities of the Michigan State Medical Society. It preserves in permanent form the best medical papers written in this state or by guest speakers at our annual and county society meetings. It is a medium through which the council and the executive committee may address the membership at large.

Its high literary quality as well as typographical appearance has been a matter of favorable comment far and wide. We believe every member of the council is thoroughly satisfied with the JOURNAL.

You have heard the editor's annual report. He has enumerated some of the special features which I need not repeat. He has, however, referred to the enlarged space given to the state and county woman's auxiliaries. We believe this is commendable. Nothing but good can come of the intelligent interest doctors' wives are taking in medical affairs. It means, in many instances, the JOURNAL goes into the home rather than the office and is read by both husband and wife.

There are some matters that must have our attention, particularly in regard to raising revenue. In the past the Council has annually allocated $1.50 of the membership dues for support or subscription to the JOURNAL. We believe every member of the society will admit that he is receiving good value for his money. This, however, does not cover the cost of printing or the editor's salary. The remainder must be made up from advertising. It is possible to increase the number of the advertising pages, but the aim of your committee has been to encourage the same discrimination in the admission of advertising matter as it has reading matter. A first class journal from cover to cover marks the dignity and high standards of the membership that supports it. Your committee would favor non-medical advertising matter as automobiles (every doctor owns one or two cars), high grade tailors, business houses, etc. A concerted effort to patronize advertisers would have a wholesome influence.

THE JOURNAL—JANUARY 1, 1935, TO DECEMBER 31, 1935.

Income:		
Advertising Sales	$ 8,051.31	
Journal Cuts	279.46	
Reprint Sales	1,687.75	
	$10,018.52	
Subscriptions to JOURNAL at $1.50 per member as determined by the council.	5,478.59	
	$15,497.11	
Expense:		
Editorial Expense	$ 3,000.00	
JOURNAL Expense	8,525.79	
Commissions	1,297.92	
Reprint Expense	1,409.53	
	$14,233.24	
Income		$15,497.11
Expense		$14,233.24
Profit—Including income from all sources		$ 1,263.87

Now, if we compare the strictly business income (advertising, reprint sales, cuts, etc.) with the strictly business expense (printing of the JOURNAL) we find that we have a deficit of $1,214.72. The question then arises: How can this deficit be overcome? Could it not be done by increasing our advertising? We believe it can and that it should be one of the duties of the council, the publication committee and the executive office (the latter of which has already gotten off to a good start) to see that this is accomplished in 1936. We could then devote the entire subscription income, at whatever rate per member the council might see fit to designate, to the editorial expense of the JOURNAL.

It might be possible to increase our non-society member subscribers by decreasing the subscription rate (which is now five dollars) to that class of individuals, and thus increase our income from that source.

The question now is: How can we increase our JOURNAL advertising? In our formal report we referred to non-medical advertising matter—as automobiles, business houses, etc. Your committee would like an expression from the council on the above question.

The policy as understood by your publication committee, and carried into effect by the editor, is the good of the physician in private practice. The aim has been to conserve his interests so far as it is possible to do so by means of a professional journal. With this in view, as you have already been told, the best scientific papers have appeared and will appear. The editorial policy has been towards the unification of the profession in its own interest with emphasis on the importance of the county medical society as the basic unit in organized medicine. The Department of Society Activity has kept the membership informed in regard to our efforts as a council and executive committee to serve its interests. The General News section, adopting the slogan of an eastern daily, has endeavored to include all the news that's fit to print. This may be modified to include all the medical news that has a statewide appeal.

We look for the help of the executive secretary in his rôle as business manager of the JOURNAL, and with the coöperation of the membership in the matter of patronizing advertisers, the future of the JOURNAL should be assured.

All of which is submitted,

H. S. CUMMINGS, M.D.
J. E. MCINTYRE, M.D.
A. S. BRUNK, M.D.
Publication Committee.

The Committee's report was approved, on motion of Drs. Powers-Heavenrich, and carried unanimously.

REPORT OF COMMITTEE ON COUNTY SOCIETIES

THE committee expresses to Dr. W. J. Stapleton, chairman of the Medico-Legal Committee, appreciation for his careful analysis of the threatened and active cases of alleged malpractice. We appreciate that much of this work cannot be made public, but, nevertheless, requires a large amount of time on the part of Dr. Stapleton and his committee.

We wish to re-emphasize Dr. Stapleton's admonition toward alertness on the part of the profession in guarding against possible suits for malpractice. The committee also wishes to stress the point made by Dr. Stapleton against the discontinuance of the defense aspect of the state society because the society will be responsible up to 23 years from date of such discontinuance in certain cases, and that insurance rates are kept lower by state defense.

In reviewing the cases of alleged malpratice as reported by Mr. Barbour it is our judgment that the medical defense is being well handled.

The secretary's report impresses this committee as exhibiting on his part careful thought and studious effort in the conduct of the duties of his office. We recommend the adoption of his report in full.

B. H. VAN LEUVEN, M.D.
V. N. MOORE, M.D.
C. E. BOYS, M.D., *Chairman.*

This Committee report was approved, on motion of Drs. Boys-Heavenrich, and carried unanimously.

REPORT OF FINANCE COMMITTEE, 1935

The Finance Committee reported through its chairman, Dr. Carstens, who discussed the financial report for 1935 in full detail, and also presented recommendations for the

Budget for 1936. Dr. Bandy spoke about financial help to erect the tablet to Dr. Harrison at Sault Ste. Marie, and on motion of Drs. Bandy-Boys, a committee was appointed to coöperate with the Chippewa County Medical Society in this matter, with power to expend funds in an amount not to exceed $100. Committee: Drs. Perry and Manthei.

SOCIETY BUDGET FOR 1936

Income:		
3,600 members at $10	$36,000.00	
Interest	1,000.00	
		$37,000.00
Appropriations:		
Defense Fund (3,600 members at 50c)	$ 1,800.00	
Journal Subscriptions (3,600 at $1.50)	5,400.00	
Rent and Electricity	760.00	
Annual Meeting	350.00	
Post Graduate Activities	1,200.00	
Committee Expense:		
Cancer Committee	$300.00	
Preventive Medicine Committee	300.00	
Medical Economics Committee	500.00	
Joint Committee on Pub. Health Educ.	500.00	
Legislative Committee	500.00	
Special Committees	750.00	
	2,850.00	
Committee Reserve	1,500.00	
Council Expense	1,800.00	
Postage	750.00	
Printing, Stationery, and Supplies	900.00	
Delegates to A. M. A.	600.00	
Stenographic	2,600.00	
Society Expense	2,000.00	
Miscellaneous General Expense	1,500.00	
Publications Expense	590.00	
Secretaries' Conference	600.00	
Secretary's Salary	2,500.00	
Executive Secretary Salary	6,000.00	
Contingent Fund	1,500.00	
Reserve	1,800.00	
		$37,000.00

BUDGET OF THE JOURNAL, 1936

Income:		
Advertising (net)	$ 7,000.00	
Subscriptions	5,400.00	
Reprint Profit	150.00	
		$12,550.00
Expenses:		
Printing	$ 8,600.00	
Editor's Salary	3,000.00	
Secretarial Expense	600.00	
Postage	200.00	
Reserve	150.00	
		$12,550.00

Each item of the Society Budget and of the JOURNAL Budget was discussed individually. After full consideration, motion was made by Drs. Carstens-Cummings that the budgets as presented be adopted and approved. Carried unanimously.

The Council Recessed for Luncheon From 12:15 P. M. to 1:15 P. M.

Medical Care of Afflicted-Crippled Children.—The Special Committee appointed to meet with the Crippled Children Commission reported on four matters which they discussed with the Commission: approval of an Alma Hospital; two problems of ethics, and the resolution of the Crippled Children Commission reviving Schedules A, B, C, and D as of July 1, 1936. The resolution follows:

Resolution On Afflicted-Crippled Child Acts Adopted January 16, 1936

BE IT RESOLVED by the Michigan Crippled Children Commission in regular meeting assembled this 16th day of January, A. D. 1936, that

Since it appears certain that the appropriation made for "Medical Care of Children" by the 1935 legislature will have been completely expended or encumbered on or before April 1, 1936, and

Since every legitimate effort has been made by this Commission and other organizations interested in proper medical service to needy afflicted and crippled children to obtain additional funds for this purpose from the Augmented State Administrative Board without success to this date, and

Since this Commission understands that the fiscal agents of the present State Administration feel that they must strictly enforce the law in respect to departments of the State Government overdrawing appropriated funds and creating deficits, now

Therefore, the Michigan Crippled Children Commission continue the present temporary fee schedules "A," "B," "C," and "D" relating respectively to afflicted and crippled children until March 31, 1936, and that on April 1, 1936, the fee schedules "B" and "D" relating respectively to hospital treatment of afflicted and crippled children also be reduced to one dollar ($1.00) per patient regardless of the number of days such patient remains in the hospital or the type of treatment he may require. Provided, that actual and necessary appliances may be charged to the State at actual cost. These fee schedules shall be in effect from April 1, 1936, until additional funds shall have been made available sufficiently to warrant another change or until June 30, 1936. On July 1, 1936, the beginning of the second year of the legislative biennium, the flat rate hospital fees of $3.25 and $4.00 per day respectively shall again become effective and charges may be made to the State at the published fee schedules "A" and "C" relating to physicians' services.

The Committee's report was accepted by The Council and ordered placed on file.

FACTS ON SOCIALIZATION OF MEDICINE

Brochure on Sickness Insurance.—Secretary Ekelund presented the problem of debates on socialization of medicine in high schools and colleges being conducted in almost all the states; that this topic, although officially not the designated subject in Michigan, was being debated in certain sections of this State. He presented the recommendation of the Public Relations Committee on the need of a brochure to send to physicians, giving them arguments to use against this socialization of medicine propaganda, and read extracts from his proposed booklet, which met the applause of The Council. General discussion. The Chair called upon Dr. J. M. Robb, who thanked The Council for appointing him to the Advisory Committee on Postgraduate Education; and also stated that he felt organized medicine has gained in its work against the socialization of medicine, that Dr. Ekelund's divisions were perfectly clear and that his brochure

has most of the things that should be commended to the profession. Further discussion brought out the necessity for a medical coördinator of relief medicine in Lansing, and included the questionnaire being circulated by the American Foundation Studies in Government.

Motion of Drs. Brunk-Cummings that The Council approve the work done on the brochure so far and instruct the Secretary and Executive Secretary to work on this towards its completion, and to refer same to the Executive Committee of The Council with power to act. Carried unanimously.

Correspondence from County Medical Societies, and miscellaneous items relative to committee expense, surety bonds, transfer of bonds in the various accounts, workmen's compensation coverage on employes, etc., were presented to The Council and appropriate action taken on each matter.

ELECTIONS

Election of Medical Secretary.—Dr. C. T. Ekelund of Pontiac was elected as Secretary of the Michigan State Medical Society on motion of Drs. Cummings-Reeder. Carried unanimously.

Election of Treasurer.—Dr. Wm. A. Hyland of Grand Rapids was elected Treasurer of the Michigan State Medical Society on motion of Drs. Moore-Heavenrich. Carried unanimously.

Election of Editor.—Dr. James H. Dempster of Detroit was elected as Editor of THE JOURNAL of the Michigan State Medical Society on motion of Drs. Carstens-Moore. Carried unanimously. Motion of Drs. Cummings-Perry that the budget of THE JOURNAL include six hundred dollars for secretarial expense in the Editor's office, and one hundred fifty dollars for the reserve fund, was carried unanimously.

Election of Medico-Legal Committee.—Drs. Angus McLean, Wm. J. Stapleton, Jr., E. I. Carr, F. B. Miner, and Wm. R. Torgerson were elected to the Executive Board of the Medico-Legal Committee, on nomination of Dr. Reeder, supported by several. Dr. McLean was elected as chairman on nomination of Dr. Heavenrich, supported by several. The Committee elects its own secretary.

Appointment of Executive Secretary.—Wm. J. Burns, LL.B., was appointed as Executive Secretary of the Michigan State Medical Society, on motion of Drs. Urmston-Brunk. Carried unanimously.

Headquarters for 1936 Annual Meeting.—Dr. Penberthy, as Chairman of the Special Committee to investigate suitable headquarters in Detroit, reported on the invitations received from four hotels and convention offices offering accommodations. Floor plans were presented and studied by The Council. After full discussion, motion was made by Drs. Brunk-Manthei that the Book-Cadillac Hotel be selected as the headquarters for the 1936 Annual Meeting. Carried unanimously.

Adjournment.—The Chair thanked all the Councilors for their effort in coming distances to attend this meeting, for their generosity in contributing two and in some cases three full days to the Michigan State Medical Society, and for their hard work and serious deliberation of the affairs and problems of the association. The meeting was adjourned at 4:30 P. M. on January 16, 1936.

Infant Feeding: Historical Background And Modern Practice

Grover F. Powers, New Haven, Conn. (*Journal A.M.A.*, Sept. 7, 1935), gives a historical summary of the practice of infant feeding and discusses the formulation of the infant's diet in modern practice, the rules for devising milk formulas, infant mortality and the psychologic era. He believes that, while the importance of an understanding of the emotional aspect of the feeding of infants is too little appreciated and that the chief problem at present arises in this domain, no real achievement in the newer knowledge of nutrition is thereby ignored. The most important aspect of the emotional problem in infant feeding is recognition that the problem exists and to a large degree may be prevented if the physician has insight and understanding of the personality of the mother and takes pains to prepare her to meet situations that are bound to occur in every case. The physician may need the assistance of a psychologist or a psychiatrist or both in therapy, but the burden of prevention is wholly that of the physician who guides the feeding. Here, if anywhere, "an ounce of prevention is worth a pound of cure." But prevention means understanding, insight, tact and patience. The physician must have all these qualities, and he must devote a great deal of time to the handling of these cases. Dr. Marian Putnam states that her most serious cases are those in which a tactless, brusque physician has scolded or otherwise occasioned resentment or feelings of guilt and inadequacy on the part of the mother. "Never show irritation at an unreasonable mother" is always a safe rule for the physician to follow.

DEPARTMENT OF SOCIETY ACTIVITY

C. T. EKELUND, M.D., Secretary

UNIVERSITY OF MICHIGAN MEDICAL SCHOOL

and

THE MICHIGAN STATE MEDICAL SOCIETY

Progressive Five-Year Program of Postgraduate Study
1936 Schedule

Short, Intensive Courses to be given in the spring of 1936

Detroit Center

Proctology.
Gynecology, Obstetrics and Gynecological Pathology.
General Practitioners' Course.
Genito-Urinary Surgery.
Pediatrics.

Ann Arbor Center

Electrocardiographic Diagnosis.
Diseases of Metabolism.
Ophthalmology and Otolaryngology.
Roentgenology.
Laboratory Technic.
Medical Military Refresher Course.

Upper Peninsula Centers

The Upper Peninsula program will be given the latter part of May.

The annual fall extension courses will begin in September. The program will be announced later for the following centers:

Grand Rapids
Flint
Battle Creek-Kalamazoo, jointly
Bay City
Manistee-Traverse City-Cadillac, jointly
Upper Peninsula

For dates of courses and other information, address:

Department of Postgraduate Medicine
University Hospital
Ann Arbor, Michigan

THE COUNCIL CHAIRMAN'S COMMUNICATION

DR. Henry Cook, Chairman of The Council, sends the following message to county medical societies:

"In contacts with Governmental Agencies and Allied Groups, the officers and committeemen of the Michigan State Medical Society are forced to recognize that the solution of most problems is possible only by the county medical society. Let us take, for example, the problem of supplemental medical relief for WPA clients. No one will disagree but that the so-called security wage given these people is insufficient for unusual expenditures, such as for a major operation in a hospital. When an extraordinary accident of this nature occurs, it is necessary that the client be aided by some agency or group. The Federal Government does not recognize this responsibility; private philanthropy is overtaxed; the state and county governments are faced with supplying such supplemental relief. Meetings with the Michigan State Emergency Relief Administrator in Lansing bring out the fact that some type of supplemental relief is being given to WPA clients in a number of counties in Michigan, in various ways. The matter of inserting a definite item for supplemental relief in the monthly budget of the county ERA is entirely in the hands of the local authorities—subject to approval by the State ERA. This approval usually is given.

"It remains, therefore, for the county medical society to contact officials of the county ERA relative to supplemental medical care for WPA employees. Regarding all other medical problems touching government, the same procedure must be followed. The Michigan State Medical Society is anxious and willing to help, but in most cases the instrumentalities must be invoked first by the county society. We urge officers of the county medical societies to present their problems to their judges of probate, boards of supervisors, county poor commissioners, and all others who have something to do with the provision of medical care for relief clients and those on the border line. A solution of most of these problems will result from a friendly understanding of the physician's viewpoint by governmental officials, and at the same time a knowledge by the physician of the scope and authority of the office holder. Fair dealing, in the interest of the patient, will always result in success for the work of the medical society, and its individual member."

POSTGRADUATE EDUCATION

THE fourth annual Medical Military Refresher Course for Reserve Medical and Dental officers of the Army, Navy and National Guard is announced by the Department of Postgraduate Medicine, University of Michigan, for April 12 to 25, inclusive.

By arrangement between the University, the Commanding General, Sixth Corps Area, U. S. Army, and the Commandant of the Ninth Naval District, U. S. Navy, reserve officers of these services, residing in Michigan, Illinois and Wisconsin, upon application to their respective commanders may obtain orders to attend this inactive duty school. An invitation has been extended to the Commanding General, Fifth Corps Area, for the officers in Ohio, Indiana, Kentucky and West Virginia.

The morning hours during the two weeks will be occupied in ward walks, observation of surgical operations, clinical conferences and demonstrations in the fields of Internal Medicine, General Surgery, and Oral and Dental Surgery. Medical officers will be required to elect either Internal Medicine or Surgery as their clinical field of study in Medical School and University Hospital. The dental officers will follow a course arranged by the School of Dentistry and the section on Oral Surgery at the University Hospital.

The afternoon and evening periods will include lectures and demonstrations on clinical subjects pertinent to civilian practice but also of military importance, military information of value to medical and dental officers, and other general discussions by members of the faculties of the University, and officers in the reserve and regular service of the Army and Navy.

Quarters will be available in the Michigan Union, the men's club at the University.

Inquiries should be directed through military channels.

SOCIAL SERVICE PLEASE NOTE

FOR at least twenty years social service and the profession of medicine have attempted by coöperative endeavor to provide medical care to indigents and people of small means. This liaison has not always been one of complete understanding. From time to time controversies have arisen, the result of divergent viewpoints on local and national issues, yet each profession is partly dependent upon the other in playing its part in the daily routine of human affairs.

In a limited sense social service itself has nothing to offer; it dispenses the substance and the services of others. It functions almost wholly as a distributing agency. Medical men have frequently been antipathetic toward the social service technique, holding that it was not sufficiently selective and exclusive in distributing medical service. Social service has sometimes assumed that it alone is best qualified to determine the amounts and kinds of medical service to be distributed without regard to

the point of view of the profession actually rendering the service.

The technique of social service is intrinsic in the operations of many governmental agencies; of Public Health nurses, of county supervisors, of political appointees in city and county government, of hospital administrators, of probate judges, of state and county relief and welfare agents, many of whom hold office through political affiliation. Trained social service personnel will be quick to agree that social service technique as practiced by these untrained gentry leaves much to be desired and in large measure is responsible for the open distrust with which the profession of medicine regards social service in its entirety.

Existing mechanisms for distributing medical service to indigents and to people of small means are seldom given the benefit of sound coöperative administration by social service and the medical profession. Result: a disappointed medical profession and a belligerent administration ready to accuse it of bad faith. Social service leaders have been well aware of the widespread breakdown of such coöperative attempts and prescribe entirely new devices and plans as the only effective remedy. They have never given sufficient thought to the *reason* for such breakdown.

It has been contended that medical care may be made available to indigents and to people of *relative* indigency through the operation of existing agencies. A great deal of force is given to this contention by factual data available in certain areas in Michigan. Successful administration in these areas differs from other and unsuccessful administrations in only one particular, namely, in the quality, the training and intelligence of the administration.

Rather than to advocate health insurance and state medicine, Social Service would do well to discover for itself the potentialities of existing agencies.

SCHEDULES A-B-C-D

Effective July 1, 1936

THE Council of the Michigan State Medical Society, at its mid-winter meeting of January 15 and 16, 1936, adopted the following Resolution prepared by its Special Committee (Dr. G. C. Penberthy, Chairman, Drs. F. A. Baker, H. H. Cummings, J. E. McIntyre, and V. M. Moore):

"The care of the crippled and afflicted child is the responsibility of the State and not of any group in the State.

"The responsibility for a high quality of medical care is the responsibility of the medical profession.

"The physicians of the State have been allowed but one dollar per case since July 1, 1935, regardless of the amount or kind of service involved. This is considered manifestly unfair.

"The Michigan State Medical Society has set up in each county a filter system for the purpose of prevention of unnecessary expense to the State. This should save the State a considerable sum of money while at the same time it will keep the standard of medical care at a high level.

"THEREFORE, BE IT RESOLVED that the medical profession of the State of Michigan urgently request the Crippled Children Commission to reinstate immediately Schedules A, B, C, and D, as a minimum remuneration for medical services rendered under these acts, payment to be deferred if necessary."

The Special Committee was authorized to confer immediately with the Michigan Crippled Children Commission for a possible solution of this problem. The Commission promulgated the following ruling on January 16, 1936:

Resolution On Afflicted-Crippled Child Acts

"BE IT RESOLVED by the Michigan Crippled Children Commission in regular meeting assembled this 16th day of January, A. D. 1936, that

"Since it appears certain that the appropriation made for 'Medical Care of Children' by the 1935 legislature will have been completely expended or encumbered on or before April 1, 1936, and

"Since every legitimate effort has been made by this Commission and other organizations interested in proper medical service to needy afflicted and crippled children to obtain additional funds for this purpose from the Augmented State Administrative Board without success to this date, and

"Since this Commission understands that the fiscal agents of the present State Administration feel that they must strictly enforce the law in respect to departments of the State Government overdrawing appropriated funds and creating deficits, now

"Therefore, the Michigan Crippled Children Commission continue the present temporary fee schedules 'A,' 'B,' 'C,' and 'D' relating respectively to afflicted and crippled children until March 31, 1936, and that on April 1, 1936, the fee schedules 'B' and 'D' relating respectively to hospital treatment of afflicted and crippled children also be reduced to one dollar ($1.00) per patient regardless of the number of days such patient remains in the hospital or the type of treatment he may require. Provided, that actual and necessary appliances may be charged to the State at actual cost. These fee schedules shall be in effect from April 1, 1936, until additional funds shall have been made available sufficiently to warrant another change or until June 30, 1936. On July 1, 1936, the beginning of the second year of the legislative biennium, the flat rate hospital fees of $3.25 and $4.00 per day respectively shall again become effective and charges may be made to the State at the published fee schedules 'A' and 'C' relating to physicians' services."

COUNCIL AND COMMITTEE MEETINGS

1. *January 8, 1936*—Subcommittee of Public Relations Committee—Probate Court, Flint,—11:00 A. M.
2. *January 8, 1936*—Special Contact Committee with Governmental Agencies and Allied Groups—Wayne County Medical Society Building, Detroit—2:00 P. M.
3. *January 8, 1936*—Subcommittee of Contact Committee with Governmental Agencies—Michigan WPA Administrator's Office, Detroit—3:00 P. M.
4. *January 8, 1936*—Legislative Committee—Wayne County Medical Society Building, Detroit—6:30 P. M.
5. *January 12, 1936*—Maternal Health Committee—Olds Hotel, Lansing—2:00 P. M.
6. *January 15-16, 1936*—Midwinter Meeting of The Council—Statler Hotel, Detroit—Three Sessions.
7. *January 22, 1936*—Subcommittee of Contact Committee with Governmental Agencies—SERA Office, Lansing—10:00 A. M.
8. *January 26, 1936*—Annual Secretaries' Conference—Olds Hotel, Lansing—All Day Session.

COMMITTEE DECISIONS

If a man owns his home, his automobile, a radio, et cetera, is entirely out of debt but is temporarily without a job, is he entitled to free, tax-supported medical care?

This is a question which was presented to the Public Relations Committee on December 22, 1935. How would you have answered it? See how the PRC handled this problem. It is item 5a of the minutes of its December 22, 1935, meeting, published in this issue of THE JOURNAL.

* * *

"To decrease the cost of probating cases under the Afflicted-Crippled Child Laws, it is the sense of the PRC that no commitments be made until the patient has gone through the Economic and Medical Filters; commitment should then be made on probate certificate signed by the family physician, and if no family physician exists, commitment should be made on probate certificate signed by an assigned physician. This activity will reduce the cases and relieve the State of the economic load, and the individual Probate Judge of much unnecessary work in his office."

—From the PRC meeting of December 22, 1935.

* * *

Shall WPA workers, as a group, be offered medical care at reduced rates, equal to 50 per cent of ordinary fees? This was a matter referred by a County Medical Society of Michigan which asked advice from the Governmental Agencies Committee of the Michigan State Medical Society. This Committee answered:

"We advise that each physician deal with each man as his private patient, making such financial arrangement as seems justified. Only in this way will the patient-physician relationship be maintained and work to the advantage of the physician as these workers are absorbed in private industry. It might be to the advantage of the County Medical Society to let the public know about this."

—From Governmental Agencies minutes of meeting of January 8, 1936.

INCOME TAX FOR PHYSICIANS

TIME of Filing: Before March 15.

Time may be extended by District Collector for cause shown.

Penalty for failure to make return may be 25 per cent of tax due.

Normal tax rate 4 per cent.

Physicians must file returns whose gross income amounted to $5,000; or whose net income amounted to:

(a) $1,000 if single or if married and not living with spouse
(b) $2,500 if married and living with spouse
(c) More than personal exemption if status changed.

If combined net income of husband and wife and dependent minor, if any, is $2,500 or over, or if their combined gross income is $5,000 or over, all such income must be reported on a joint return, or on separate returns of husband and wife.

Taxpayer is responsible for obtaining blanks.

OF SPECIFIC INTEREST TO PHYSICIANS are the following items:

GROSS INCOME is the total amount received by a physician during the year for professional services, plus profits from investments or speculations, and compensation and profits from other sources.

NET INCOME is gross income less personal exemptions and expenses.

EARNED INCOME up to 10 per cent of net income, but not in excess of $14,000, may be deducted from net income. $3,000 of physician's net income from whatever source may be considered earned income.

EXPENSES DEDUCTIBLE FOR PHYSICIAN:

Cost of supplies, such as dressings, drugs, clinical thermometers, etc.
Cost of operating automobile used in making professional calls
Dues to professional societies (but not dues to social clubs)
Rent paid for office rooms
Cost of fuel, light, water, telephone, etc., used in office
Hire of office assistants
Subscriptions to medical journals and books
If the useful life of furniture, instruments and equipment or books is short, amounts currently expended therefor.
Expenses incurred attending medical conventions
Insurance premiums paid against professional losses
Expense in defending malpractice suit
Loss and damage to equipment by fire, theft or other cause not compensated by insurance or otherwise recoverable
Laboratory expenses, when under corresponding circumstances they would be deductible if related to physician's office.
Travelling expenses incurred on strictly professional business.

DEPRECIATION AND OBSOLESCENCE:

THE PRINCIPLE governing determination of rates of depreciation is that the total amount claimed as depreciation during the life of the article, plus the salvage value of the article at the end of its useful life, shall not be greater than its purchase price, or fair market value as of March, 1913, if purchased before that date. If it is found the length of life of an article has been estimated erroneously, a new estimate should be made and deduction then made accordingly.

FAIR ESTIMATE OF YEARLY DEPRECIATION on following articles:

Automobiles	25 per cent
Ordinary medical libraries X-ray Equipment Physical Therapy Equipment Electrical Sterilizers Surgical Instruments Diagostic Apparatus	10 per cent
Office Furniture	5 per cent

POST GRADUATE STUDY not deductible.

AUTOMOBILES: Original cost not deductible.

Expense of operating and depreciation deductible as follows:

Cost of gasoline, oil, tires
Insurance
Repairs
Garage rental (if garage not owned by physician)
Chauffeurs' wages
Estimated depreciation must be spread over entire life of car, not time in owner's possession
If used partly for pleasure or by family, only so much of expense used for professional practice may be deducted
Expense of car used merely to transport physician to and from a limited office practice is not proper for deduction.

SPECTACLES: Sales of spectacles, etc., by oculists may be included as income, and cost of articles sold deducted as expense. Charges for services should be kept separate on physician's books from charges for spectacles, etc.

A somewhat more detailed article on the above subject is to be found in the *Journal of the American Medical Association* for January 11, 1936.

MINUTES OF MEETING OF THE MATERNAL HEALTH COMMITTEE

Lansing, Sunday, November 24, 1935

1. The meeting was called to order in the Olds Hotel, Lansing, at 2:00 P. M. Present—Drs. Alexander M. Campbell, Grand Rapids, chairman; Norman F. Miller, Ann Arbor; Harold W. Wiley, Lansing; Harold Furlong, Pontiac. Absent—Dr. Ward F. Seeley, Detroit.

2. A review of the accomplishments of the Committee of Maternal Health was made and activities for the coming year were discussed.

3. It was planned to have a committee write a letter to the presidents of the County Medical Societies requesting them to appoint for each society a Maternal Health Committee. Dr. Norman Miller stated that he would get up a letter as an example of the type of communication to be sent to the County Medical Society presidents.

Dr. Harold Wiley was asked if he would contact Dr. C. C. Slemons, State Health Commissioner, to determine if any money could be available to defray the expenses of the stenographic work and other expenses that might be accrued to carry on with this work.

4. The question of publicity was also discussed with the idea of carrying the message of Maternal Health and its improvement to the public by talks before Luncheon Clubs, The Federated Women's Clubs, by Radio and other methods.

5. The problem of better clinical facilities for teaching Obstetrics at the University of Michigan was discussed and considered to be fundamental. Dr. Miller stated that it required at least 500 more obstetrical cases to furnish adequate clinical material for the students at Ann Arbor, and methods were discussed relative to obtaining such cases from Welfare cases throughout the State.

6. The unsatisfactory method of maternal care of women on relief throughout the State was discussed. The Committee took under consideration the advisability of its attacking this unsatisfactory state of affairs but no action was taken.

7. The Committee felt the magnitude and importance and responsibilities and duties devolved upon it and hopes to meet frequently and agreed that Lansing was probably the most central point at which these meetings could be held.

ALEXANDER M. CAMPBELL, M.D.

MINUTES OF MEETING OF THE PUBLIC RELATIONS COMMITTEE

Lansing, Sunday, December 22, 1935

1. *Roll Call.*—The meeting was called to order by Dr. L. F. Foster, Chairman, at 2:40 P. M., in the Hotel Olds, Lansing. Present were Drs. L. F. Foster of Bay City, F. T. Andrews of Kalamazoo, E. I. Carr of Lansing, R. H. Holmes of Muskegon, F. B. Miner of Flint, and A. H. Whittaker of Detroit; also Dr. C. E. Boys, Chairman of Council's Committee on County Societies, and Executive Secretary Wm. J. Burns. Absent were Drs. Philip Riley of Jackson, J. J. Walch of Escanaba, and A. V. Wenger of Grand Rapids (excused).

2. *Minutes.*—The minutes of the meeting of November 13, 1935, were read and approved.

3. *New Members.*—The Chair welcomed the two new members of the Committee, Drs. Andrews and Holmes.

4(a). *Organization Work.*—The Chair called upon the Executive Secretary for a report on the key groups appointed to date in the various county medical societies. This report showed a few loose ends in the State. The Chair stressed the necessity of contacting individual county medical societies.

4(b). In order to contact all county medical societies, the seventeen Councilor Districts were allocated to the various members of the Public Relations Committee, by mutual agreement:

These members will be available to attend county medical society meetings in the allocated districts, in company with the Councilors. In this way, the remaining societies and districts will be covered, and the loose ends will be gathered in. This will integrate the filter system in every county in the State and thus help the State and the public.

5(a) *Afflicted-Crippled Child Acts.*—A question as to whether the filter system should include crippled children resulted in a decision that it was so intended, and the orthopedic men who attended meetings of the Executive Committee of The Council understood this arrangement. Another question referred to commitment of the child of a man who owns his home, his automobile, radio, etc., is out of debt but temporarily without a job: Discussion brought out that the law states the judge "may" send such a case to the hospital for tax supported medical care but the law does not make it mandatory. Motion of Drs. Holmes-Carr that since the definition of indigency is discretionary with the probate judge, this Committee feels a person should not be committed under these two acts if there is a probability of payment to the physician on either a deferred or part payment plan. Carried unanimously.

Discussion resulted in the opinion that the appointing of the Economic Filter is the prerogative of the probate judge, but the county medical society should offer advice to him and concur in the appointment of the Economic Filter, which should be a social service agency in which the medical profession has confidence. Individuals who are interested in rounding up cases should not be on the Economic Filter, which is designed primarily to save the State money by cutting down the cases to those requiring urgent work.

To Cut Costs of Probating.—The Committee discussed the statement that the cost of probating some cases was between $6 and $7 per case. Motion of Dr. Miner-Whittaker: To decrease the cost of probating cases under these Acts, it is the sense of this Committee that no commitments be made until the patient has gone through the economic and medical filters; commitment shall then be made on probate certificate signed by the family physician, and if no family physician exists, commitment shall be made

on probate certificate signed by an assigned private physician. Motion carried unanimously.

Motion of Drs. Andrews-Holmes: In the definition of medical filter, there be added to the items of "urgency and necessity" the following: "and to estimate the necessary period of hospitalization and treatment." Motion carried unanimously.

Motion of Drs. Carr-Miner that a communication be addressed to the Probate Judges respectfully suggesting that they urge people to apply for commitments through a private physician. Motion carried unanimously. This activity will reduce the cases, and relieve the State of the economic load, and the individual probate judge of much unnecessary work in his office.

Motion of Drs. Whittaker-Miner that the public relations committee in each county medical society be an advisory committee to the probate judge. Motion carried unanimously.

The definition of the terms "indigent," "urgent," and "necessary" is to be referred to the Crippled Children Commission.

5(b) *Approval of Hospitals.*—The case of Smith Memorial Hospital at Alma was discussed and on motion of Drs. Whittaker-Holmes was presented to the Executive Committee of The Council to refer to the appropriate committee for immediate investigation, as this problem is jeopardizing the filter system in Gratiot County and must be settled at once. Carried unanimously.

6(a). Motion of Drs. Holmes-Whittaker that this Committee recommend that the M. S. M. S. prepare a brochure with arguments against the socialization of medicine and that it be sent to every member of the M. S. M. S.; and that editors of county medical societies' bulletins be urged to reprint the brochure. Carried unanimously.

6(b). *Muskegon County Letter.*—The correspondence relative to WPA medical care was read and discussed. Motion of Drs. Whittaker-Miner that this question be referred to the Executive Committee of The Council with the recommendation that it be sent to the Committee on Governmental Agencies which shall keep in contact with the Muskegon County Medical Society regarding this problem. Carried unanimously. Motion of Drs. Holmes-Carr that the Public Relations Committee advise the Muskegon County Medical Society of the above action with the request that Muskegon County Medical Society please withhold action until notified of the decision of the Committee on Governmental Agencies. Carried unanimously.

7. *Committee References.*—The references from the Legislative Committee and from the Committee on Preventive Medicine were presented. Motion of Drs. Holmes-Andrew that due to the lateness of the hour and the fact that these items are not urgent that they be placed on the agenda of the next meeting of the PRC. Carried unanimously.

8. *Contact with Public.*—Dr. Whittaker presented his verbal outline whereby physicians could effect necessary contact with the public. After discussion, motion of Drs. Holmes-Andrews that Dr. Whittaker be requested to write up his plan in detail so that it may be mimeographed and sent to each member of this Committee, and that it be placed on the agenda of the next meeting of the PRC. Carried unanimously.

9. The meeting was adjourned at 6:05 P. M. The Chair thanked all for their attendance at this Sunday session, and for their advice.

MINUTES OF MEETING OF SPECIAL CONTACT COMMITTEE TO GOVERNMENTAL AGENCIES AND ALLIED GROUPS

Detroit, Wednesday, January 8, 1936

1. *Roll Call.*—The meeting was called to order by Dr. Henry Cook, Chairman, in the Wayne County Medical Society Building at 2:25 P. M. Those present were Dr. Cook of Flint, Dr. B. R. Corbus of Grand Rapids, Dr. L. F. Foster of Bay City, Dr. T. K. Gruber of Eloise, Dr. C. R. Keyport of Grayling, and Dr. R. H. Pino of Detroit. Also present were Secretary C. T. Ekelund of Pontiac and Executive Secretary Wm. J. Burns. Absent were Dr. H. H. Cummings of Ann Arbor; Dr. Grover C. Penberthy of Detroit (excused).

2. *WPA Medical Care.*—The Chair announced that an appointment had been obtained for a meeting with Mr. H. L. Pierson, State WPA Director, at 3:00 P. M. this date, and requested the Committee to discuss certain WPA matters for presentation to Mr. Pierson. These included the matter of a rumored plan for providing medical care to WPA workers; the system of examining WPA workers to ascertain ability to carry on prescribed work; and the question of supplemental medical care for WPA workers. After a discussion of these three points, the Chair appointed Dr. Gruber and Mr. Burns as a Committee to interview Mr. Pierson.

Later, this Subcommittee reported on its meeting with Mr. Pierson and Mr. Wm. F. Dorn, Compensation Director: that the rumored plan does not seem to exist; that the matter of physical examinations of WPA workers is left entirely to the District Director and that no WPA funds were available for this medical work; and that the Federal Government cannot provide supplemental medical care for WPA workers. The report was accepted and placed on file.

3. *SERA Medical Care.*—The Committee discussed all phases of this subject and efforts of various counties and state medical societies to devise plans to provide medical care to unemployables and employables on relief and WPA. Motion of Drs. Corbus-Keyport that representatives of the Michigan State Medical Society be appointed to consider with Wm. Haber, SERA Administrator, certain of the preliminary and essential features of various plans in order to get his opinion and to stress that the profession sees the necessity of a medical advisor who shall act as coördinator. Motion carried unanimously.

The Committee: Drs. Cook, Ekelund, Foster, Gruber, and Penberthy.

4. *Muskegon County Question.*—The Committee discussed the Muskegon County question presented by a WPA official in that County. (This matter referred to this Committee by the Public Relations Committee, M. S. M. S.) Full discussion ensued. Motion of Dr. Foster, seconded by several: This Committee hopes that no plan to care for WPA workers in a group or groups will be accepted by the County Medical Society. We advise that each physician deal with each man as his private patient, making such financial arrangement as seems justified. In this way only will the patient-physician relationship be maintained and work to the advantage of the physician as these workers are absorbed in private industry. It might be to the advantage of the County Medical Society to publicize this. Motion carried unanimously.

5. *Infirmary Hospital.*—From the Crippled Children Commission came a question as to whether an infirmary hospital in Iron County should be approved for the care of afflicted children. Motion of Drs. Corbus-Foster that this matter be referred to Councilor Manthei with all information and a

request for his investigation and advice on this. Motion carried unanimously.

6. *Physical Rehabilitation Program.*—The Chair read a letter from the West Virginia State Medical Association relative to its physical rehabilitation program of unemployable relief clients for the purpose of sending many back into gainful employment. The consensus of opinion of the Committee was that this was good public policy, and also good for the physicians who were getting a little work. The Committee instructed the Executive Secretary to obtain the mechanics of this program from Secretary J. W. Savage of West Virginia.

7. *Survey of Medical Care of Pensioners.*—Dr. Pino spoke of the proposed survey in Michigan of the medical needs of old age pensioners.

8. *Adjournment.*—The meeting was adjourned at 5:20 P. M., after the Chair had thanked all for their attendance and advice.

MINUTES OF MEETING OF THE LEGISLATIVE COMMITEE

Detroit, Wednesday, January 8, 1936

1. *Roll Call.*—The meeting was called to order by Dr. H. H. Cummings, Chairman, at 7:45 P. M., in the Wayne County Society Building at Detroit. Present were Dr. Cummings of Ann Arbor, Dr. F. B. Burke of Detroit, Dr. L. G. Christian of Lansing, Dr. Henry Cook of Flint, Dr. L. J. Gariepy of Detroit, Dr. C. F. Snapp of Grand Rapids. Also present were Secretary C. T. Ekelund of Pontiac, Dr. L. F. Foster of Bay City and Executive Secretary Wm. J. Burns. Absent was Dr. H. E. Perry of Newberry.

2. *Minutes.*—The minutes of the meeting of December 4, 1935, were read and approved.

3. *Reports of Subcommittees* on their studies of several important matters were presented in detail and approved, with commendation.

4. *Bill to Amend Afflicted-Crippled Persons' Laws.*—Dr. Gariepy recommended a new commission to administer these laws and others and explained his proposal by charts. Dr. Ekelund read extracts from his proposed brochure. Report was given that the Subcommittee on Relief Medicine of the Committee on Economics has been requested by the Executive Committee of The Council to furnish the Legislative Committee with information on its survey of the costs of the afflicted-crippled child laws, as same progresses. Full discussion. No action taken at this time, it being felt that these matters must be gone over repeatedly, and that progress must be made slowly but surely. Dr. Ekelund's suggestion re appointment of a medical director by the SERA will be presented to Dr. Wm. Haber, SERA Administrator, by a Subcommittee of the Special Contact Committee to Governmental Agencies and Allied Groups.

5. *Bill to Curb Unauthorized Practice of Medicine.*—Report will be made at next meeting on this matter.

6. *Integration of Medicine.* Dr. Burke recommended that this should be considered at a later date after the work on hand has been completed.

7. *Barbituric Bill.*—The Executive Secretary reported on action of the A. M. A. re this legislation. He was instructed to write the fourteen states in which such legislation exists and ask how the laws are operating and what are the results. He was also instructed to obtain the views of the NARD and the MS Retail Drug Association toward such a bill.

8. *Eye Examinations.*—Dr. Burke reported on the ophthalmologists' activity re blind advertising of physicians M.D. employed by jewelry stores, etc., to examine eyes. He will report further progress at the next meeting.

9. *Physicians' Liens.*—The Executive Secretary reported on past attempts in Michigan to obtain legislation giving physicians first class liens in insurance cases, and in estates. He cited House Bill 135 of 1933 and House Bill 651 of 1933.

10. *Taxation of Physicians' Equipment.*—Dr. Gariepy brought up the matter of taxation of physicians' equipment. This problem is one which should be approached first by the county medical society, it was felt.

11. Several communications from county medical societies were read, and appropriate action taken.

12. *Adjournment.*—The meeting was adjourned at 10:55 P. M. after the Chair had thanked all for their attendance and good advice.

COUNTY SOCIETIES

LOOK TO YOUR COUNTY MEDICAL SOCIETY

The State Medical Society Executive Committee and the Committee of Nine, representing the Michigan State Medical Society, the State Hospital Association and the State Association of Probate Judges have held several meetings, attempting to work out the care of crippled and afflicted children.

Representatives of certain hospitals at one of these meetings made two suggestions: first, that the filter systems be appointed by the hospitals and not by the doctors. (Probably some superintendent has certain stooges ready.) The second proposition was that certain hospitals agree direct with the crippled children's commission for complete care of the children, the hospitals to arrange for the medical part. This last looks like an attempt to make the doctor ultimately an employee of the hospital. Fortunately, both of these plans were defeated, but they point toward a menace. After all, the organization looking most earnestly after the doctor's rights is our own Society, and it must not be subordinate to any other.—*The Bulletin of the Calhoun County Medical Society.*

EATON COUNTY

The personnel of the new administration of the Eaton County Medical Society which takes over at once for the period of the next eighteen months according to the newly adopted Constitution and By-laws is as follows: President, Dr. H. A. Moyer, Charlotte; vice president, Dr. A. W. Myers, Potterville; secretary, Dr. T. Wilensky, Eaton Rapids; treasurer, Dr. J. W. Davis, Charlotte; delegate, Dr. A. G. Sheets, Eaton Rapids; alternate, Dr. P. Engley, Olivet.

T. WILENSKY, *Secretary.*

MIDLAND COUNTY

On December 27, the Midland County Medical Society held a special meeting, at which time Dr. L. F. Foster, of Bay City, chairman of the Public Relations Committee of the State Medical Society, addressed the meeting on the new correlation of activities in the State Society.

He especially discussed the new set-up in reference to the Afflicted Children's Commission and how the County Society can coöperate in carrying out the new agreement entered into by the Probate Judges Association, the State Hospital Association and the State Medical Association.

The new president of the Society, Dr. W. D. Towsley, will appoint the necessary committees at once.

Judge Dage LaGoe, the probate judge, and Mr. Elroy Sias, County Poor Commissioner, were present at the meeting and agreed to coöperate with the Society in carrying out the provisions of the new set-up.

DAVID LITTLEJOHN, M.D., Dr.P.H., *Secretary.*

MONROE COUNTY

Monroe County Medical Society has had an active season. We have four new members: Dr. Edgar C. Long, Monroe, who is specializing in Surgery; Dr. A. D. Blanchet, Monroe, Dr. Albert H. Reisig, Monroe, and Dr. Stanley C. Penzotti, Dundee, are in general practice.

Our programs have been as follows: November 21, Dr. Osborne A. Brines, Detroit, "The Bacteriology and Pathology of Pneumonia"; December 19, Dr. E. S. Gurdjian, Detroit, "Head Injuries"; January 16, Dr. Harold K. Shawan, Detroit, "Goiter."

The Monroe County Welfare Relief Commission has an excellent program for medical services to welfare clients. It has been found most practicable by doctors, patients, and welfare workers. During the last eight months of 1935, $4,178.18 was paid to doctors for 2,592 medical services. The advisory committee appointed by the medical society to work with Mr. Russell H. Clark, relief administrator, consists of Dr. J. J. Siffer, Dr. H. W. Landon, Dr. Florence Ames.

Our delegate to the State Society is Dr. D. C. Denman, Monroe; alternate, Dr. J. H. McMillin, Monroe.

FLORENCE AMES, M.D., *Secretary.*

MUSKEGON COUNTY

Extracts from *Special Bulletin* giving Rules for Hospitalizing Afflicted Children under State Aid.

As was announced at the annual meeting and has been announced in the MICHIGAN STATE JOURNAL, the Council of our State Society has entered into an agreement with the Michigan Hospital Association, Crippled Children's Association, Probate Judges Association, State Administrative Board, and Auditor General's Office to care for Afflicted Children in our local hospitals.

It is necessary that we all coöperate to furnish this service, but to only those whose financial condition makes it an absolute impossibility to pay for private services and to admit to the hospitals only those patients whose medical needs are urgent and necessary. (*Note:* This does not necessarily mean that these must be emergencies. Where material delay is incompatible with the child's health it is an urgent case.)

The following simple rules will be applied. Please take careful note of these and follow them closely.

First: Emergency Cases. Any child under twenty-one years of age may be admitted to either hospital by his family physician. Within twenty-four hours the physician bringing in the patient must notify a member of the Medical Filter Committee. Within forty-eight hours the parent or guardian of this child must apply to the office of the Probate Judge. George Vandermolen, the County Welfare Agent, has been agreed upon by the representatives of the Medical Society and the Probate Judge to act as the Economic Filter. He will investigate and, if the parents are unable to pay for private medical attention, will order the child admitted under the Afflicted Child's Act. If he finds that the parents are able and are willing to pay a minimum amount of $4.00 a month (half of the payments to go to the hospital and half to the physicians) the case is referred back to the admitting physician as a private case.

Mr. Vandermolen is the *sole* judge of the economic status of the patient. He will, however, welcome inquiries or suggestions regarding this phase.

The medical record of the case will be reviewed at a subsequent Saturday morning meeting of the Medical Filter Committee. The admitting physician may be called upon to justify the emergency of the case. The Medical Filter will have authority to approve or disapprove the conduct of the case if deemed necessary. He will estimate the probable days' stay in the hospital.

Chronic.—Any child under twenty-one years old who comes to you requesting or needing hospitalization, having satisfied *you* as to the necessity, will be sent to the Probate office for a certificate which you will complete and have returned by the patient to the Probate office. The Probate office will refer the patient to Mr. Vandermolen, and after passing his investigation, the patient will appear before the Medical Filter on a Saturday morning at 8:00 o'clock. The patient will be completely examined by this committee and if it is found that hospitalization is urgent and necessary, this will be recommended to the Probate Judge, who will commit the child to a local hospital, and the admitting physician will assume charge of the case. A bill will be rendered through the hospital then for services under Schedule "A" of the Crippled Children's Commission.

The State Society advises that we coöperate with these people in providing deferred or part payment plan.

There are bound to be a number of rough spots in this set-up. Patience, reasonableness, and honesty will assure a satisfactory program. The Probate Judge is going out of her way to coöperate with our local and State Societies in this matter. The doctors who are serving on the Medical Filter are giving their time gratis, and deserve your coöperation.

Your duty as a citizen of the State is to keep State expenses at a minimum. Your duty as a physician is to impress the private practice idea on your patients and those with whom you have contacts.

The Medical Filter for January consists of Dr. V. S. Laurin, Dr. F. N. Morford, and Dr. Henry Pyle. The first of February a doctor will be appointed to take Dr. Pyle's place for a period of three months. The first of March a doctor will be appointed to take the place of Dr. Morford for three months. The first of April one will be appointed to replace Dr. Laurin for three months. By this method no excessive demand for time is made on any member. There is a fee established by law for every certificate filled out if the patient is admitted. It is our understanding that this money is available and an attempt will be made to have the physician compensated for this service.

Remember:

First.—If you have an emergency, bring it in to the hospital as you would any other patient. If you believe it should come under the Afflicted Child's Act, notify any member of the Medical Filter within twenty-four hours. Instruct the parents or guardians to apply to the Probate Judge's office within forty-eight hours.

Second.—Any other patient who, you feel, should come under this Act is to be directed to the Probate Judge's office for certificate which is to be returned after completion to that office.

Third.—Submit you bill according to Schedule "A" to the Superintendent of the hospital.

Fourth.—Certify only those cases which you believe are urgent and necessary.

Fifth.—It is the endeavor of County and State Societies to re-educate these patients to become private patients, wherever possible.

Sixth.—Play ball with this organization. If difficulties arise, confer with the Medical Filter.

Seventh.—Mr. Vandermolen is the *sole* judge of patient's economic status.

Eighth.—The Medical Filter is the *sole* judge of the patient's medical status.

NORTHERN MICHIGAN MEDICAL SOCIETY

(Antrim, Charlevoix, Emmet, Cheyboygan Counties)

The regular monthly meeting of the Northern Michigan Medical Society was held at the Perry Hotel, Petoskey, January 9, 1936, president Engle in the chair. Minutes of the last meeting were read and approved. Correspondence was read and discussed and reports of committees were heard. President Engle of Petoskey then introduced Judge of Probate Gilbert of Emmet County, who gave a brief talk on the work of the Probate Court with regard to crippled and afflicted children in his county. Judge Rueggesseger of Charlevoix County then spoke on the work in his county. The Reverend Mr. Weaver, county agent of Emmet County, then gave a short talk on his phase of the work. These talks were followed by a general discussion of these matters by the entire Society. Drs. McMillan and Armstrong were appointed to the program committee for next month.

E. J. Brenner, *Secretary.*

ST. CLAIR COUNTY

The first regular meeting of the new year was held Tuesday, January 7, at the Harrington Hotel, Port Huron. Twenty-six members and five guests attended. President J. H. Burley presided. Dr. Alvin Price of Detroit addressed the meeting upon the subject, "The Modern Treatment of Pneumonia." Dr. Price spoke informally covering in a practical manner the usual therapeutic agents and measures, many of which have been in vogue for years.

The speaker laid especial emphasis upon the use of oxygen, preferably in a tent, also the use of pentnucleotide to restore the leukocyte balance whenever the daily count shows a decline in the leukocytosis.

The speaker stressed the use of Felton's Serum especially for Type one, two and seven, infections. Detailed explanation was given as to new method of typing sputum and the tests to be made for serum sensitivity in both eye and skin before the intravenous use of same. The usual dosage, at four hour intervals, according to Dr. Price, should be 40,000 as an initial dose, followed by two doses of 20,000 units each.

The speaker touched upon the use of artificial pneumothorax in the treatment of lobar pneumonia but stated that an insufficient number of cases had been so treated for any definite decision as to its benefits. The discussion was opened by Dr. George Waters followed by several others, after which Dr. Price closed.

A rising vote of thanks was given the speaker for coming up in such weather in order to address the Society.

A short business meeting followed the scientific program, after which the meeting adjourned.

At the regular meeting of Saint Clair County Medical Society held at the Harrington Hotel, Port Huron, Tuesday, January 21, 1936, twenty-seven members and six guests were present. President J. H. Burley, presided.

The minutes of the meeting of January 7, 1936, were read and approved. A letter from the office of the Prosecuting Attorney relative to irregular and illegal practitioners was read by the chairman of the Medico-legal Committee, Dr. H. O. Brush.

The president then introduced Dr. R. C. Connley of Detroit, who read a paper on "Newer Methods of treatment in Gastro-intestinal Disorders." Dr. Connley divided the subject into four parts, taking up in the order named, "Gastric Ulcer," "Gallbladder Disease," "The Unstable Colon" and "Constipation." The paper was interesting and to the point and was very much enjoyed by those present. The discussion was opened by Dr. E. W. Meredith, followed by Dr. R. M. Burke, Dr. A. J. MacKenzie, Dr. H. O. Brush, Dr. A. L. Callery and Dr. J. C. S. Battley. Following Dr. Connley's closing discussion, the meeting adjourned.

George M. Kesl, *Secretary-Treasurer.*

WASHTENAW COUNTY

A regular meething of the Washtenaw County Medical Society was held at the Michigan Union on Tuesday, December 10, at 6:15. Dinner was served to forty-eight members. About sixty attended the scientific meeting.

The speaker, Dr. C. D. Camp, was introduced by President O. R. Yoder. Dr. Camp gave a very interesting talk on the subject, "Disturbances of Sleep."

During the business session which followed, the report of the auditing committee, consisting of Drs. Carleton Peirce, Vincent Johnson, and Harold Jacox, was read and accepted. This report made known a balance in the treasury of $455. The committee recommended an appropriation of as much as $5.00 a month if necessary to provide adequate clerical assistance for the keeping of more up-to-date records of the business affairs of the Society.

The nominating committee submitted a report naming the following doctors as candidates for office during the year 1935: President, Norman F. Miller; vice president, Margaret Bell; secretary-treasurer, John V. Fopeano; delegates: John Wessinger, Dean Myers, John Sundwall; alternates: S. L. LaFever, H. B. Britton, Warren E. Forsythe; censors: W. J. Wright, Lester Johnson, W. M. Brace.

The report was adopted and candidates elected.

The secretary reported that the membership now numbers 146. There are several physicians in the University Hospital who become eligible each year. There are also a few in the county outside the University who should be approached upon the subject of membership. It might be well to have a membership committee to approach these men.

Dr. Howard Cummings reported the activities of the State Society in reaching an agreement with the State and Hospital Association authorities on the subject of afflicted child care in the State. He emphasized the need of local support of this agreement. He urged the appointment of a Public Relations Committee to function in drawing up plans for local coöperation in this work as well as in other matters involving public relations. It being necessary to have the names of these committeemen in Lansing immediately, Dr. Yoder had appointed this committee on December 9 and the names of the members had been forwarded to the office of the State Medical Society. The committee consists of: John S. DeTar, Milan; Lester J. Johnson, corner Liberty and Fifth Avenue, Ann Arbor; J. J. Woods, 19 N. Washington St., Ypsilanti.

The meeting adjourned at 8:35 P. M.

On January 14, 1936, a dinner and business session at 6:15 P. M. was followed by a symposium on "Acute Upper Respiratory Infections," Dr. A. C. Furstenberg acting as chairman. The symposium consisted of the following papers: "Acute Rhinitis," Dr. J. H. Maxwell; "Sinus Complications," Dr. R. W. Teed; "Ear Complaints," Dr. D. W. Myers. General discussion on the part of the members was concluded with a Summary by Dr. Furstenberg.

J. V. Fopeano, *Secretary.*

WOMAN'S AUXILIARY

Mrs. A. M. Giddings, President, 22 Riverview Ave., Battle Creek

Mrs. Kenneth Lowe, Secretary-Treasurer, 107 Elizabeth St., Battle Creek

Mrs. L. C. Harvie, Press Chairman, 341 Brockway Place, Saginaw

Mrs. A. V. Wenger, Grand Rapids
Vice President, Woman's Auxiliary, Michigan State Medical Society.

Dear County Presidents and Members:

Our National Society under its president, Mrs. Rogers N. Herbert, is emphasizing the importance of the part played by auxiliary members in the activities of lay organizations. It is most fitting that we, as doctors' wives, should be active agents in the formation of public opinion, and directors of effort along the lines concerned with health problems, and the preservation of medical ideals. It will be interesting to learn the results of a national survey now being made to show how great is our potential influence through other channels than our own organization. This survey is being conducted in Michigan through our department of Public Relations under its chairman, Mrs. Ledru O. Geib.

It is an encouraging fact that we do have varied interests, and it is surprising how much can be accomplished even over the bridge table to combat misunderstanding and senseless gossip. An auxiliary member must be well informed, first of all, along health and medical lines. She must be alert to her opportunities, and be ready to accept, with dignified self confidence, challenges for service in women's clubs, Parent-Teacher organizations, and the like. In rendering intelligent service in that way she is adding strength to the auxiliary and to the merited prestige of the medical profession. Being fully convinced of the value in influence of such a position, your president has recently accepted a vice chairmanship of the Social Welfare Department in the Michigan State Federation of Women's Clubs. Mrs. Frank W. Hartman, president of the Wayne County auxiliary, holds a similar position in the same department.

The American Medical Association is cognizant of the importance of the auxiliaries' position by depending upon us to disseminate information regarding its radio program, a copy of which is in the hands of every county president. People generally are interested in medical topics and with such a splendid program of interesting subjects we should be able with no great effort to build up a large radio audience. Tell your neighbors about it. Mention the subject at your bridge club, and in your church circle. Ask for permission to make the announcement in your woman's club meeting or in your Parent-Teacher group.

It might be a good thing for us to borrow, for the occasion, the Boy Scout motto, "Be Prepared." Then we will be able to respond intelligently when our friends and acquaintances call upon us for information and suggestions along lines in which we are primarily interested. This, to me, is one of the primary objectives for members of our organization. Talk it over; talk it up, in your meetings. Send comments or suggestions to your president and they will be printed on our pages in the Journal.

With best wishes, I am

Sincerely yours,
(Mrs. A. M.) Leah M. Giddings.

* * *

As chairman of Program, I earnestly request that each county chairman study the outline and material sent to you so that you may be able to discuss these at your auxiliary meetings. It is your duty to impress the fact upon the members that we are expected to study health questions. Let us realize this request from the National Auxiliary and do something before the year's program is closed.

The American Medical Association feels that this is a very important service we can render to the medical profession. We must be intelligent on these subjects ourselves before we can create interest in the community.

I have sent an announcement of the January radio program to each auxiliary. Let us all become enthusiasts over this program. Please make announcements before clubs and send some comments to the American Medical Association office, 535 N. Dearborn St., Chicago.

There are no better speakers than Dr. Fishbein and Dr. Bauer, so you really have something to offer radio listeners. All *Hygeia* subscribers can find programs announced in advance.

Be a good auxiliary and do your part.

(Mrs. G. C.) Bernice Hicks.

Hygeia Subscriptions Soaring In Michigan

The Kellogg Foundation has taken out 1,965 current subscriptions to *Hygeia* to be distributed in the following counties: Barry, Branch, Calhoun, Eaton, Allegan, Van Buren and Hillsdale.

* * *

Kent County has placed *Hygeia* in 184 rural schools.

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County News

Bay County.—The Auxiliary to the Bay County Medical Society held its regular meeting December 11, 1935, at the home of Mrs. A. D. Allen. A fish dinner was served to thirty-two members in the recreation room.

After a business meeting conducted by the president, Mrs. L. F. Foster, a talk was presented by Miss Agnes Halloran, Bay County Health Nurse, who explained the health program and described the work being done by that department.

Mrs. F. T. Andrews, of Kalamazoo, past president of the Auxiliary to the State Society, was present and gave an interesting talk, telling of past work accomplished and future plans of the organization.

Mrs. L. G. Christian, of Lansing, and Mrs. I. W. Greene, of Owosso, also were guests.

The remainder of the evening was spent at bridge and Christmas prizes were presented to the high score-holders at each table.

(Mrs. K.) GENEVIEVE M. STUART, *Secretary.*

* * *

Calhoun County.—The Calhoun County Auxiliary met on January 7, 1936, at the Nurses' Lodge of the Nichols Hospital for an all day session to sew for the hospital, with Mrs. J. E. Cooper and Mrs. Winslow in charge.

A considerable number of garments consisting of T-binders, slings, tray cloths, abdominal binders and pneumonia jackets, were completed. At noon a cooperative luncheon was enjoyed, the Nurses' Lodge furnishing hot coffee and cream as well as silverware and china.

Next month's meeting will be held at the Leila Hospital.

LOIS M. UPSON, *Publicity Chairman.*

* * *

Kalamazoo County.—Twenty-eight members of the Woman's Auxiliary to the Kalamazoo Academy of Medicine were present at the meeting held Tuesday, December 15, 1935, at the home of Mrs. C. B. Fulkerson. A bounteous coöperative dinner, with turkey as a special treat, was served at 6:30 p. m.

The dining table was attractively decorated with red candles. A Christmas tree and poinsettias used throughout the house added to the spirit of the season.

Members brought gifts for the old people on relief, who received a Christmas gift from the Community Christmas tree.

Following a very brief business meeting "contract" bridge was enjoyed. Mrs. Fulkerson was assisted by Mrs. W. D. Irwin, of Kalamazoo and Mrs. W. R. Young, of Lawson.

(Mrs. F. M.) WILMA G. DOYLE,
Press Chairman.

* * *

Saginaw County.—The annual Christmas Party of the Saginaw County Auxiliary was enjoyed by fifty-two members at the Hudson Party House on December 17. Dinner was served at 6:30, three large tables being used, which were centered with miniature Christmas trees and red tapers in silver holders. At each place was a tiny candlestick and before the dinner was served an impressive candle-lighting ceremony was held. While members were lighting the candles they sang "Silent Night, Holy Night," led by Mrs. Robert Leckie, soloist for the evening.

Following the dinner Mrs. Leckie, accompanied by Mrs. Norman Popp, sang several numbers and led the group in singing "Jingle Bells" and other Christmas songs.

Plans were made during the business session for a Public Relations meeting to be held in April at the South Intermediate School which will be open to all with special invitations to all P. T. A. groups, Women's Clubs, and others.

The remainder of the evening was spent at games, each one taking home a prize.

(Mrs. L. C.) DELTA A. HARVIE,
Press Chairman.

Wayne County.—The December activities of the Woman's Auxiliary to the Wayne County Medical Society began with a tea, December 3, for the wives of those doctors attending the Radiological Society of North America, which met in Detroit. Active among the hostesses were Dr. Mary Thompson Stevens, Mrs. Edward G. Minor, Mrs. Howard Doub and Mrs. Clarence Weaver.

The regular meeting of the Auxiliary was held Friday, December 13, with Dr. William J. Stapleton, Jr., the guest speaker, discussing Radio Advertising.

The sale of Christmas seals in the hospitals of the city was directed by Mrs. Fred Meader, assisted by her co-chairman, Mrs. George B. Hoops, and was gratifyingly successful.

The annual Christmas party for younger children of members, sponsored by the Wayne County Medical Society with members of the Auxiliary as hostesses, was given Saturday afternoon, December 14. Mrs. E. C. Baumgarten, co-chairman of the social committee, arranged a musical program, with a magician and Santa Claus in attendance and refreshments followed. Each guest had been asked to bring a gift for a needy child.

That same evening, members of the Social Committee of the Auxiliary served refreshments to the three hundred guests attending the Dramatic Section's productions at the Playhouse.

The holiday season festivities closed December 27 with the 'teen age party, also given annually by the W. C. M. S. Mrs. J. Whitlock Gordon, chairman of the Social Committee had charge of the arrangements for music and dancing.

(Mrs. Milton A.) WINOGENE E. DARLING.

MICHIGAN'S DEPARTMENT OF HEALTH

C. C. SLEMONS, M.D., Dr.P.H., Commissioner
LANSING, MICHIGAN

Progress in Sanitation

One of the most notable advances in public health for Michigan during the past year has been the unprecedented improvement in public water supplies and sewage disposal systems. As a result largely of work relief projects involving federal aid, communities have been enabled to construct new systems or make needed additions or alterations in existing ones. A program of construction that, in the ordinary course of events, it would have taken years to accomplish is well on its way to completion.

The most marked improvement has been in sewage disposal facilities.

Sewage treatment plants at Charlevoix, Charlotte and Paw Paw, all of which are PWA projects, have been completed and are in operation. Plants at East Tawas and Tawas City which were constructed with the assistance of CWA and ERA have also been completed. Additions have been made to the plant at Holland and to the one at Fremont. These two were financed independently of any governmental aid. The City of St. Ignace has also substantially completed a plant and a major portion of a sewer system which began under the CWA and has been continued under the various relief organizations since then.

The cities of Owosso, Alma, and Bessemer have plants under construction which should be completed shortly after the first of the year. The plants at Alma and Bessemer are PWA projects

while the one at Owosso was independently financed. Ann Arbor, Battle Creek and Jackson all have plants under construction. They should be completed sometime during 1936. The plant at Jackson is one which will clean up one of the worst cases of pollution in the state, leaving only the city of Lansing as a major contributor to the pollution of the Grand River.

Bids have been received for plants at Gladstone, Grand Haven and Monroe although work has not been started on any of these projects. Muskegon received bids for an intercepting sewer and expects to receive bids in December for the construction of a sewage treatment plant.

The City of Howell has authorized the issuance of bonds to defray the cost of construction of a sewage treatment plant. Ludington and Pentwater are beginning construction of their intercepting sewers leading to a proposed sewage treatment plant. The Village of Dexter is also proceeding with the construction of a sewerage system and a sewage treatment plant.

Of great interest is the receiving of bids for the construction of another section of the Detroit River interceptor, which indicates a resumption of activity leading to the elimination of pollution from the Detroit River. This is, of course, the major problem in the state from the standpoint of stream pollution. With the award of this contract, it seems likely that the subsequent contracts for the remainder of the intercepting sewer and the sewage treatment works will follow within the next year or two. Several other cities have filed projects for the construction of sewage treatment plants including Niles, Pinconning, Spring Lake, South Lyons, Three Oaks, Allegan, Big Rapids, Clare and Cassopolis.

The Villages of Bronson and Whitehall and the communities of North Park and Galewood, which are subdivisions near Grand Rapids have begun the construction of sewerage systems. The City of Midland has begun the construction of a main trunk sewer and a relief sewer for the portion of the city.

The year has marked the beginning of a certification of sewage plant operators which is being undertaken by the department for the purpose of improving the quality of personnel in charge of the operation of sewage treatment works. In the past it has been found difficult to secure proper operation of plants.

In the field of public water supplies, improvement has also been marked.

During the year with the assistance of PWA a filtration plant was completed at Port Hope and a zeolite softening and iron removal plant was completed at East Lansing. Through the same agency, filtration plants are under construction at Marine City and Muskegon, and an iron removal plant has been approved for Northville. A water supply system including both the construction of the well and a distribution system under this agency has been obtained by: Elberta, Minden, Centerville, Bear Lake, Colon and Clifford, and a new supply only was obtained by Standish.

Under WPA, filtration plants are being started at New Baltimore and Big Rapids. A clear water reservoir is under construction at Wyandotte, a standpipe at Edmore, and a water pumping station at Elk Rapids. Through the previous relief agencies such as ERA, Benton Harbor secured an aerator to the softening and iron removal plant and Alpena added to its clear water reservoir.

Although it is not definitely reported what assistance a federal agency gave, the following municipalities added to their water supply by construction of new wells: Grand Haven, Almont, Chesaning, Muskegon Heights, Lansing, Frankfort, Douglas, Imlay City, Nashville, Pentwater and Three Rivers, while reservoirs were built at Frankfort and Lowell.

In addition to the foregoing, there has been a very extensive program of additions to the present water distribution systems in many municipalities and the replacement of old equipment.

During the year 360 construction permits have been issued for waterworks and sewerage systems or additions, alterations, or extensions to existing systems.

Improvements at Biologic Plant

A number of improvements have been made at the Biologic Plant during the past year as a result of federal grants for labor and some money for materials.

Four wooden buildings have been replaced with three fireproof structures, a root cellar has been constructed for the storage of food for rabbits and guinea pigs, and the foundation laid for a small animal house to be built in the future.

Of the three new buildings, one houses bleeding, injecting and operating rooms for horses, another is a small animal house for the bleeding and carrying of the stock of laboratory animals, and the other is used for finishing smallpox and rabies vaccine and housing animals under test.

The razed wooden buildings have been made into a storage warehouse for farm machinery and bulk supplies.

A Diphtheria Analysis

The encouraging downward trend of diphtheria has apparently been arrested. The total of cases since January 1, 1935, has been consistently below the total for the corresponding period in 1934 until the week ending December 7. Then, for the first time, the cumulative total for 1935 exceeds that for 1934.

Analysis of cases reported from January 1 to December 7, 1935, from some of the larger cities reveals interesting facts. The case rate per 100,000 for the state is 11.7. Detroit's rate is 11.4. Four other cities with populations of more than 50,000 have rates that exceed that of Detroit, and the state, namely, Pontiac with a rate of 48.7, Flint with 28.7, Lansing with 15.9 and Saginaw with 15.6. These rates are approximate and subject to correction since three weeks of December remain to be added, and there will be changes due to reallocation of cases and changing of diagnosis.

Of the cities having more than 50,000 population, Grand Rapids has one case, giving a rate of .6, and Jackson and Kalamazoo with one case each have a rate of less than 2.0.

Eight cities with populations between 25,000 and 50,000 have had no cases reported, and 11 cities in the same class have had from 1 to 5 cases each.

Less fortunate cities are Escanaba whose 11 cases give it a rate of 74.3, River Rouge with 11 cases and a rate of 59.1, Battle Creek with 14 cases and a rate of 31.3 and Bay City with 13 cases and a rate of 27.7.

The total number of deaths for the state for the first ten months of 1935 was 38 compared to 33 for the same period of 1934. The apparent rise in case incidence may still further increase the past year's deaths over those for 1934.

Toxoid, especially for younger children, is obviously indicated.

"Banish the future. Live only for the hour and its allotted work. Think not of the amount to be accomplished, the difficulties to be overcome or the end to be attained, but set earnestly at the little task at your elbow, letting that be sufficient for the day."

—OSLER.

OBITUARY

Dr. B. W. Babcock

Dr. B. W. Babcock of Grand Rapids died suddenly at his home, January 8, 1936. The cause of death was cardiac disease. Dr. Babcock was born at Lamont, Michigan, fifty-six years ago. He was a graduate of Washington University, St. Louis, Missouri. He practiced medicine in Rockford before coming to Grand Rapids twelve years ago. He is survived by his wife; one daughter, Mrs. Bernard Boshoven; one son, Clay; one grandson, all of Grand Rapids; one sister, Mrs. Agnes Ransdall; and one brother, D. F. Babcock of St. Louis, Missouri.

Dr. Charles Godwin Jennings*

Dr. Charles Godwin Jennings, Detroit, died at the hospital which bears his name, January 9, 1936, after a brief illness of pneumonia. Dr. Jennings was one of the best known internists, not only in Michigan but in the United States. Born in the state of New York in 1857, he received his early education in the schools of Seneca Falls and in 1875 graduated from the Mynderse Academy preparatory to entering Cornell University. He began the study of medicine in a preceptor's office at Seneca Falls and in 1876 matriculated and entered upon the study of medicine at the Detroit College of Medicine, whence he graduated in 1879. A significant feature in Dr. Jennings' career is the fact that he had continued to be a student. Following graduation he pursued courses in physics, chemistry, French, German and English literature under private tutors. His industry was boundless. With his large private practice, he found time to serve as attending physician and chairman of the board of trustees and of the medical of the Charles Godwin Jennings Hospital; consulting physician Harper Hospital (he was head of the department of Medicine and chairman of the Executive Committee of the Medical Board from 1912 to 1925); consulting physician to the Grosse Pointe Cottage Hospital, Sanitarium, the United States Marine Hospital, St. Mary's Hospital, 1882 to 1890, and attending physician to the Woman's Hospital from 1895 to 1900.

Dr. Jennings' teaching positions were for the most part in the Detroit College of Medicine, where he lectured on chemistry from 1881 to 1882, chemistry and diseases of children 1883 to 1888, physiology and diseases of children 1889 to 1893; he was professor of pediatrics from 1893 to 1895, when he combined pediatrics and medicine to 1910. He was professor of medicine from 1910 to 1918.

His professional society membership list, past and present, include the following: Wayne County, Michigan State and American Medical Associations. He was president of the Wayne County Medical Society in 1903; chairman of the section on diseases of children A. M. A. 1893, and vice-chairman of the medical section in 1920; President of the Detroit Academy of Medicine, 1918; Master, American College of Physicians, chairman of the Board of Governors from 1927 to 1931, and in 1931 vice president and regent. Dr. Jennings was president of the American Therapeutic Society in 1922 and president of the American Congress of Physicians in 1927.

During the war he was first lieutenant of the Medical Reserve Corps, U. S. Army, 1917, and captain of the Medical Corps, U. S. Army, 1917 to 1919. He was on duty at Camp Grant as chief cardiologist in 1917.

Dr. Jennings was a voluminous writer on medical subjects. He was editor at different times of at least three national periodicals, namely, associate editor of the *Annals of Clinical Medicine,* the *Archives of Pediatrics,* 1898 to 1912, and editor of the *Microscope,* 1885 to 1890. In addition to this he was contributor to the following works of composite authorship: Tice's Practice of Medicine, the Therapeutics of Internal Diseases, and, in 1889, the Cyclopedia of Disease of Children, besides numerous medical papers and essays in national and state medical journals.

As an ardent fly fisherman, Dr. Jennings was well acquainted with the streams of Michigan as well as the more remote regions of Canada where trout and salmon are found. Expert with the rifle as well as the shotgun, he hunted big game in the American and Canadian Rockies and in Newfoundland and New Brunswick. He had been a sailor and racing skipper from early life.

He is survived by one son, Dr. Alpheus F. Jennings of Detroit.

Dr. Hal M. Parker

Dr. Hal M. Parker, of Monroe, was found dead in his home December 23. He lived alone, his wife having died in 1933. It was thought that the doctor, who was found with his clothes on, lying on a couch, had been dead since the 20th of December. Dr. Parker had not been in good health for several years. He was born on January 23, 1865, and studied medicine at the Detroit College of Medicine, from which he graduated in 1889. He had pursued postgraduate work at Heidelberg, Germany, and at Harvard. Following his graduation he practiced at Metamora and Delta, Ohio, and also in California. He returned to Monroe, Michigan, twenty-five years ago, where, since that time, his practice had been limited to diseases of the eye, ear, nose and throat.

Dr. Dayton L. Parker of Detroit, and Dr. Thad Parker of Marley, Colorado, brothers, survive him.

Dr. James T. Upjohn

Dr. James T. Upjohn died at his home in Kalamazoo, January 25, 1936. He graduated from the University of Michigan in 1885. He was a former official of the Upjohn Pharmaceutical Company of Kalamazoo. He served three terms in the Michigan Senate and two in the House of Representatives, ten years in all. Dr. Upjohn was interested in real estate development in the upper peninsula and helped organized the Munising Paper Company and the Detroit Pulp and Sulphite Company.

Dr. Peter Stewart

In the passing of Dr. Peter Stewart of Royal Oak, organized medicine lost one of its grand old men, a gentleman of the old school. He was the soul of honesty and integrity, a despiser of all that was mean and sordid, a stickler for the highest ethics in his profession, and an exemplary husband and father and good neighbor. Born in 1869, graduated from the University of Michigan in 1891, he had practiced in Hadley and Royal Oak until the date of his death, having been in Royal Oak the last sixteen years.

Modest and unassuming but dignified in his manner, he invoked the confidence of all those with

*See editorial in this number of the JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY.

whom he came in contact. In failing health for the past two years, his indomitable will would not allow him to give up. During the last week of his illness he could not relax and after a desperate struggle finally succumbed to a heart complication on January 2.

The sum of all tributes would be, "A good man has finished his work and passed on."

J. S. Morrison, M.D.

GENERAL NEWS AND ANNOUNCEMENTS

The 100 Per Cent Club of the Michigan State Medical Society

Ingham County Medical Society
Muskegon County Medical Society
Oceana County Medical Society
Ontonagon County Medical Society.

The above county medical societies have paid dues in full for each and every member of the County and State Medical Society (as of January 23, 1936).

As of January 21, 1936, 101,000 cases were on WPA in Michigan, and 69,000 cases were under SERA in the 83 counties of the State.

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Dr. Walter J. Cree of Detroit is spending part of the winter in New Orleans. Dr. Cree reports that there is sunshine most of the time and weather that on the whole resembles a northern spring.

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Listen in on the American Medical Association's dramatized radio programs each Tuesday afternoon at 5:00 o'clock, Eastern Standard Time. Suggest to your patients that they do likewise.

* * *

Dr. Grover C. Penberthy, President of the Michigan State Medical Society, addressed the Bay County Medical Society in Bay City on January 2, 1936, on the subject, "Compensation Cases, Fees and Discussions."

* * *

Wayne University College of Medicine presents a course in Medical Economics to its senior class, composed of 76 students. The lectures are given every Saturday morning, beginning at 8:00 A. M., 629 Mullett St., Detroit.

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The Yakima County Medical Society of Washington has a brochure on sickness insurance and on the socialization of medicine. For copies, write Dr. H. F. Alwood, President, Yakima County Medical Society, Yakima, Washington.

* * *

Dr. Shattuck W. Hartwell of Muskegon has been appointed to the Committee on Preventive Medicine by President Penberthy to take the place of Dr. Roy H. Holmes, who has been appointed as a member of the Public Relations Committee.

The State Bar of Michigan has moved its offices to 412 Olds Tower, Lansing, Michigan. An executive secretary is soon to be appointed to handle detail work for the lawyers, and to accomplish the integration of the bar in accordance with recent legislation in Michigan.

* * *

U. S. Public Health Service announces openings for senior medical internes in positions existing now and others which will occur about July 1. Second year medical internes interested in the service as a career may procure information by writing the U. S. Public Health Service, Washington, D. C.

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Due to length of the annual reports of officers and committees, published in this issue of The Journal, the itemized report of receipts and disbursements for 1935 will be published in the March issue.

The February issue contains the auditor's report submitted by Ernst & Ernst.

* * *

The wages of employees of the WPA and other federal employees may not be garnisheed in the state courts, according to a recent ruling of the Attorney General of Michigan. It is pointed out that the Federal Government and its instrumentalities are exempt from garnishment, providing they are not engaging in private enterprises.

* * *

The Subcommittee on Relief Medicine of the Medical Economics Committee, Michigan State Medical Society, is composed of the following physicians: Dr. S. W. Insley, chairman, Detroit; Drs. E. W. Bauer, Hazel Park; T. K. Gruber, Eloise; Harold Miller, Lansing; Vernor M. Moore, Grand Rapids, and A. B. Murtha, Pontiac.

* * *

A brochure giving the facts on the practice of medicine as it now exists, and on the tireless efforts of certain well-paid propagandists to turn the profession into a "trade," is being prepared by the Michigan State Medical Society. In a few weeks, a copy will be sent to every member of the Michigan State Medical Society. Doctor, know the Truth, and Spread your Knowledge.

* * *

Counties are liable for the expense of dependent children in need of hospital care, states an opinion from the Attorney General of Michigan which holds that Probate Courts shall, when the health or condition of the child requires, cause such child to be placed in a public hospital or in an institution for treatment or special care, or in a private hospital or institution for special care.

* * *

Opportunities for physicians: A. N. Buhler, City Clerk of Mackinaw City, writes that that community offers an opportunity for a general practitioner. If interested, write the City Clerk.

Mackinac Island has an opening for a physician, due to the recent death of a practitioner on the Island. For details write Dr. J. E. McIntyre, Secretary, State Board of Registration in Medicine, Hollister Building, Lansing.

* * *

The Michigan State Medical Society's 71st Annual Meeting will be held in Detroit at the Book-Cadillac Hotel next September. Although the exact date has not been decided as yet by the Council, it is probable that the week of September 20 will be chosen, as this time is free from conflicts with the meetings of other medical organizations. Plan to attend. Get your hotel reservations early. It is anticipated that 2,500 will register.

Dr. J. L. Johnson, in his President's Page in the *Maine Medical Journal,* says: "The Medical Association will not be what it should be; the practice of medicine will not be what it should be; the individual welfare of you, Mr. Individual Doctor, will not be what it should be until *you yourself personally* wake up and take more interest in the affairs of the State Association.

* * *

Dr. J. M. Robb, Detroit, was appointed by The Council of the Michigan State Medical Society as a member of the Advisory Committee on Postgraduate Education. This is a permanent standing Committee of the Michigan State Medical Society which arranges the postgraduate work done jointly by the Michigan State Medical Society and the Department of Postgraduate Medicine of the University of Michigan.

* * *

Did you study the radio debate on state medicine? This was held over the National Broadcasting Company network on November 12, 1935. Speakers for the affirmative were William T. Foster and Bower Aly; speakers for the negative were Dr. Morris Fishbein and Dr. R. G. Leland. Every practicing physician should know the arguments of both sides. They were published in *The Bulletin of the American Medical Association,* last issue.

* * *

Program Committee chairmen of county medical societies, attention! Do you wish a member of the Public Relations Committee of the Michigan State Medical Society to address your membership? If so, contact the Executive Office, 2020 Olds Tower, Lansing, 5-3355. To comply with your requests, the various Councilor Districts have been assigned to the nine members of the Public Relations Committee, as an aid to the work of each Councilor.

* * *

The Bulletins being published by various county medical societies of Michigan are well worthy of congratulation. The *Jackson Bulletin* has a new cover for its February number, and the innovation of a perforated sheet on which is printed the list of officers; this is a help to the members who wish to clip the sheet for reference purposes. Congratulations are due the editors of county society bulletins for their efforts and excellent results.

* * *

The Northwest Regional Conference will be held at the Palmer House, Chicago, on Sunday, February 16, beginning with breakfast at 8:30 A. M. Dr. R. H. Pino of Detroit, Chairman of the Medical Economics Committee of the M.S.M.S., will discuss the subject "Standardization of the Activities of the Committees on Medical Economics of the Midwest and Northwest." All members of the Michigan profession are invited to attend this interesting conference.

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"**There is a gentleman** now living in Detroit who remembered when as a young man he rode on horseback through the State each year to inspect the Indian villages, and there was not then a white man living in the State five miles west of Detroit. This was in 1820." Extract from the *Medical History of Michigan,* volume 1.

A fascinating story of medicine from the earliest days of Michigan history down to the present—every physician in the State should have these two volumes. Reduced price, $2.50 each.

* * *

Literature relative to state medicine, sickness insurance, and socialization of medicine, will be supplied by the Michigan State Medical Society to the library of every high school, college, and university in the State of Michigan. A total of over 1,000 packages of material will be mailed from the Executive Office in Lansing during February.

Any member of the Michigan State Medical Society who desires one of these packages may procure same by writing the Executive Secretary, 2020 Olds Tower, Lansing.

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The first annual golf tournament of the Michigan State Medical Society will be held in Detroit next September on the Sunday preceding the Annual Meeting of the Michigan State Medical Society. This was announced by Dr. Grover C. Penberthy, President, on the occasion of "Michigan State Medical Night" in Jackson on January 21, 1936. Dr. Penberthy has promised to present the "President's Cup," and Dr. Frank Reeder will donate the "Speaker's Cup." If you can swing a putter, plan to be on hand at this glorious affair next September.

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The annual lectures under the auspices of the Beaumont Foundation of the Wayne County Medical Society will be held in Detroit on March twenty-third and twenty-fourth. Dr. Charles A. Doan, professor of medicine and director of the department of medical and surgical research, Ohio State University, will be the lecturer. His subjects are (1) Functional Reciprocity between the Myeloid and the Lymphatic Tissues: A Fundamental and Physiological Law with Definite Clinical Significance, (2) Hemolytopoietic Equilibrium with Special Reference to Pathologic Physiology of the Spleen. These lectures are open to all members of the Michigan State Medical Society who wish to attend.

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Military Surgeons to Meet in Detroit

The Association of Military Surgeons of United States will hold their national convention in Detroit, in 1936. Lieutenant Colonel Burt R. Shurly was named general chairman of the Executive Committee, and Major Bernhard Friedlænder was named membership chairman.

All officers who served in the Spanish War, World War, and all officers of the Medical Reserve Corps are eligible for membership in this Association. All the doctors who are eligible are requested to send their names to the membership chairman, Major Bernhard Friedlænder, 300 Rowena, Detroit, Michigan and help make the coming convention a success.

* * *

Post-graduate conferences for physicians will be held at the Herman Kiefer Hospital auditorium at 10:00 A. M. each Wednesday morning during the month of February, as follows:

February 5:	**10-11**	**Pathology of Tuberculosis**
	11-12	**Scarlet Fever**
February 12:	**10-11**	**Preventive Measures in Tuberculosis**
	11-12	**Whooping Cough**
February 19:	**10-11**	**Diagnosis (Childhood and Adult Type Tuberculosis)**
	11-12	**Diphtheria**
February 26:	**10-11**	**Differential Diagnosis of Tuberculosis**
	11-12	**Anterior Poliomyelitis**

These conferences are sponsored by the Wayne County Medical Society, the Detroit Tuberculosis

Sanatorium, and the Detroit Department of Health. They are arranged for by the Contagious Disease and Tuberculosis Committees of the Medical Society.

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The American Medical Directory, 14th Edition, will be published in 1936. All members of the Michigan State Medical Society are urged to check their listings in the American Medical Directory and if any changes are to be made, to send same to the American Medical Association, 535 North Dearborn Street, Chicago, Illinois, before February 15, 1936. The names of members of the State Medical Society are listed in capital letters.

It is important that you are listed as a member. Some men who have not been so listed have possibly lost appointments with industrial firms, insurance companies, railroads, etc. They may have been members and let their membership lapse, or new men in the community who failed to join their local society in time to indicate this information in the Directory.

Protect yourself. Check your name. Write the A.M.A. today.

* * *

The filter system for the medical care of afflicted-crippled children has been integrated in Michigan in all but two counties (as of January 21, 1935). This is remarkable work, considering that the filter system was unknown until the Committee of Nine met in Lansing on October 30, 1935. In less than three months, the county medical societies of the state, those covering seventy-nine of the eighty-three counties, have integrated a new system and completely organized a threefold set-up: (a) appointed a Public Relations Committee, (b) established a medical filter, and (c) arranged for an economic investigation committee to work in an advisory capacity with the probate Judge.

The county medical societies of Michigan are able to accomplish any plan which works for the benefit of the public—proof of this has been given! The help of the Michigan State Medical Society is always available, to assist in integrating programs through all the eighty-three counties of the State.

* * *

Dr. Henry Cook Addresses the Senior Group

The regular monthly meeting of the Senior Group of Physicians was held at the Wayne County Medical Society at noon (luncheon), January 15. The group was addressed by guest speaker Dr. Henry Cook of Flint, chairman of the Council of the Michigan State Medical Society. We print Dr. Cook's address in full in the March number of the JOURNAL. After Dr. Cook's address, he was presented with a gavel by Dr. Henry A. Luce. On the silver band about the gavel was inscribed Dr. Cook's name and the occasion of the presentation.

Among those present were: Drs. R. L. Clark, J. W. Ferguson, J. M. Hart, Andrew Biddle, Emil Amberg, Chester Paull, L. J. Hirschman, G. Penberthy, Henry Cook (Flint), William J. Stapleton, Jr., H. B. Garver, A. S. Brunk, C. E. Boys (Kalamazoo), F. E. Reeder (Flint), Henry A. Luce, J. H. Dempster, L. M. James, Bruce Anderson, A. L. Cowan, Wm. Fowler, C. S. Ballard, H. D. Kidney, W. C. Laurence, M. E. Dawforth, J. H. Greenwood, J. H. Hodger, Wm. Hackett, H. G. Palmer, Hugh Harrin, James W. Scott, A. G. Huegli, S. H. Knight, A. K. Northrop, Walter J. Wilson.

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The American College of Physicians Will Meet in Detroit

The Twentieth Annual Session of the American College of Physicians will be held in Detroit with headquarters at the Book-Cadillac Hotel, March 2-6, 1936.

Dr. James Alex. Miller, of New York City, is president of the college, and has arranged a program of general scientific sessions of great interest to those engaged in the practice of internal medicine and associated specialties. Dr. James D. Bruce, Vice President in Charge of University Relations, University of Michigan, is vice chairman of the Committee on Arrangements, and has in charge the preparation of an all-day program to be conducted at the University of Michigan on Wednesday, March 4. Dr. Walter B. Cannon, Professor of Physiology at Harvard University Medical School, will deliver the annual Convocation oration on "The Rôle of Emotion in Disease." Dr. Miller's presidential address will be on "The Changing Order in Medicine." About fifty eminent authorities will present papers at the general scientific sessions while clinics and demonstrations will be conducted at the Harper, Receiving, Ford, Grace, Herman Kiefer and Children's Hospitals, of Detroit.

* * *

The Coöperative Medical Advertising Bureau—what is it? This may be the inquiry of some physicians of this State. The Bureau is a department of the American Medical Association and has been in existence twenty-three years. Its purpose is to service the State Journals in the procurement of high-class ethical advertising. Of the thirty-four state medical journals in the United States, the Coöperative Medical Advertising Bureau serves thirty-two. The value of the Bureau as a selling organization cannot be overestimated: it presents to a prospective advertiser the attractive proposition of reaching over eighty thousand physicians in forty-two states. It offers him an opportunity to bring his message to this preferred-customer group every month with the least possible trouble. One piece of copy is all that need be prepared for thirty-two outlets. No wonder that advertisers placed with the Bureau during the twenty-three years of its existence a total gross of $2,027,869! In 1935 alone, the gross advertising amounted to $134,477, distributed among the thirty-two journals. To the individual State Journals, the Bureau has been of invaluable help not only in placing advertising, in securing copy and plates, but in the indispensable feature of collecting for the contracted business. Literally, the Bureau assumes the burden of removing the bitterness from a very large cup, and it accomplishes its purpose successfully. More that that, it limits its income to actual expenses, and each year sends back to the individual journal a cash rebate, which generosity is not part of its agreement. In this State, the rebate in 1935 cut the net cost of the Bureau's commission to 13.1 per cent on the total business placed in our JOURNAL. This is a very low cost for the high type and generous amount of service rendered. During its existence, the Bureau has rebated to the State Journals, out of its commission of 20 per cent, the amazing sum of $130,798!

This is a thumbnail answer to the question about the Coöperative Medical Advertising Bureau. Roughly, it handles about five-eighths of the advertising placed in your Journal. Its use throughout the years has proven to be "good business."

* * *

Dr. Max Ballin Memorial Lectures

The North End Clinic, Detroit, has put on an interesting post-graduate course of lectures on Disease of the Gastro-intestinal Tract, given Thursday evenings, January 9 to February 7. Those given were as follows:

1. *January 9*

The Important Phases of the Applied Physiology

of the Gastro-intestinal Tract and Biliary Tract—A. C. Ivy, M.D., Professor and Head of the Department or Physiology and Pharmacology, Northwestern University Medical School, Chicago, Illinois.

2. *Jauuary 16*

The Diagnosis and Management of Choleystitis.—B. B. Vincent Lyon, M.D., Assistant Professor of Medicine, Jefferson Medical College and Chief of Clinic, Gastro-intestinal Department, Jefferson Hospital, Philadelphia, Pennsylvania.

3. *January 23*

(a) Indication for Surgery in Gall Bladder Disease and Post-operative Results—C. D. Brooks, M.D.

(b) Diagnosis of Gall Bladder Disease by X-ray—(15 minutes)—Arthur R. Bloom, M.D.

4. *January 30*

(a) Pitfalls in the Diagnosis of Colon Disease—Louis J. Hirschman, M.D.

(b) Interpretation of Gastro-intestinal Symptoms—(15 minutes)—S. G. Meyers, M.D.

The February lectures are as follows:

5. *February 6*

Indications for Surgery in Peptic Ulcer and Post-operative Results—Frederick A. Coller, M.D., Professor of Surgery, University of Michigan, Ann Arbor, Michigan.

6. *February 13*

Non Gastro-intestinal Diseases (excluding neurosis)—Leon Bloch, M.D., Attending Physician on the Staff of the Michael Reese Hospital and Assistant Clinical Professor at Rush Medical College, Chicago, Illinois.

7. *February 20*

(a) Management of the Peptic Ulcer Patient—Frederick G. Buesser, M.D.

(b) Newer methods in the Treatment of Peptic Ulcer—(15 minutes)—(LaRostidin, Synodal, Vaccines, Silicon Dioxide, Etc.)—David J. Sandweiss, M.D.

8. *February 27*

Nervous Dyspepsia—Walter C. Alvarez, M.D., Head of Section in Division of Medicine, Mayo Clinic, and Professor of Medicine in Graduate Medical School in the University of Minnesota, Rochester, Minnesota.

The last is the Dr. I. L. Polozker Memorial Lecture. The lectures are open to the medical, dental and allied professions.

The Heart in Hypertension

George Fahr, Minneapolis (*Journal A. M. A.*, Nov. 2, 1935), points out that 55 per cent of the appalling death rate consequent to essential hypertension is due to heart failure. Moreover, heart failure of some degree is nearly always present in cases of essential hypertension in which death occurs in uremia or from apoplexy or cerebral softening. The heart in hypertension shows left ventricular hypertrophy and dilatation with varying grades of replacement scarring in the muscle. There is some coronary arteriosclerosis present in 90 per cent of the cases. The coronary narrowing is responsible for scars found in the heart muscle. A very high percentage of patients with angina pectoris and coronary arteriosclerosis have high blood pressure complicating the cardiac picture. Hypertension and coronary arteriosclerosis are so intimately and frequently associated that they should be considered together and the term "hypertensive heart disease" or "hypertension heart" should connote coronary involvement. What has been termed "chronic myocarditis" is usually the result of high blood pressure and coronary artery disease and not the result of infection. Heart failure in the clinical sense does not develop in hypertension until many years (from ten to twelve) have passed unless the coronary disease accompanying the high blood pressure becomes very severe or unless some other cardiac complication is present. Many patients with hypertension live fifteen years or more and finally die of one of the other consequences of hypertension, though some degree of heart failure may have been present previously or at the time of death.

Use of Heat in Diseases of Nervous System

Clarence A. Patten, Philadelphia (*Journal A.M.A.*, Sept. 7, 1935), points out that heat is frequently used in the treatment of both organic and functional nervous disease and provides a very effective therapeutic agent. It is used in many ways both locally and generally. Heat is generally used systemically in the treatment of the psychoses and is usually of considerable advantage if used over a long period of time. It is definitely of greater value in the agitated and maniacal mental states because of its sedative effect, but it is not particularly effective in the depressions except occasionally in agitated melancholia. The means by which heat is applied in mental states in the order of their efficacy are: the continuous hot bath, the cold pack, the warm pack, cabinet sweats and conditioned heat. The continuous hot bath is used particularly in cases of maniacal excitement and maintains a steady temperature of about 96 to 98 F. and sometimes more. Neither cold nor warm packs are used in the presence of circulatory or cardiac derangement or when the patient is in a very weakened condition. Electrical cabinet baths are frequently used for coöperative mental patients for the purpose of obtaining the effects of varying degrees of heat over a short period of time as well as elimination through free perspiration. Various forms of heat therapy are used in the organic psychoses, particularly dementia paralytica. In dementia paralytica the continuous baths are helpful when the patients are markedly excited, but only for the sedative effects. For the purpose of combating the disease, more vigorous heat therapy is needed. Cabinet bakes, electric heat blankets and the conditioned heat apparatus are quite effective. In the psychoneuroses the so-called tonic electric cabinets given every day and followed by hot and cold contrast showers afford a great stimulus to the patient and in addition occupy a certain part of his time, which is of importance. Hydrotherapy in the form of hot and cold showers alone can be given daily. Electric "baking" with hydrotherapy is only a part of the general treatment of the neuroses and dependence must not be placed on it alone. Heat is of the greatest value in inflammations of the peripheral nerves and in vascular diseases in which implication of the nervous system is evidenced by pain of greater or lesser severity. In certain vascular diseases of the limbs, such as erythromelalgia, Raynaud's disease, thrombo-angiitis obliterans, thrombophlebitis and endarteritis obliterans, dry heat applied to the diseased parts more or less constantly over a period of days causes an alleviation of the symptoms of pain. Even in chronic diseases of the nervous system, such as hemiplegia or lateral sclerosis, when the limbs are spastic, heat will decrease the spasms and contractures, at least for a time, and will moderate other symptoms. In chorea of the acute variety, provided no heart disease exists, any method of applying heat generally will be found to produce remarkably sedative results. Most frequently the continuous tub is employed, but for an hour or two at a time.

GROUP OF GUESTS AT JACKSON DINNER AND LOCAL OFFICERS

Seated left to right: Claude Keyport, Grayling; I. W. Greene, Owosso; J. H. Dempster, Detroit, Editor Michigan State Medical Journal; Grover Penberthy, Detroit, President Michigan State Medical Society; Charles Dengler, President Jackson County Medical Society; Henry Perry, Newberry, President-elect Michigan State Medical Society; Howard Cummings, Ann Arbor; J. E. McIntyre, Lansing; A. G. Sheets, Eaton Rapids.

Standing left to right: F. T. Andrews, Kalamazoo; Frank Reeder, Flint; Henry Cook, Flint; Phil Riley, Jackson, Chairman; L. G. Christian, Lansing; Paul Urmston, Bay City; A. S. Brunk, Detroit: Carl Brucker, Lansing; L. F. Foster, Bay City; Wm. J. Burns, Lansing, Executive Secretary Michigan State Medical Society.

STATE SOCIETY NIGHT AT JACKSON

The Jackson County Medical Society held a State Society Night in place of their regular monthly meeting at the Hayes Hotel, on Tuesday evening, January 21, 1936. Dr. Philip Riley, vice speaker of the house of delegates, was the entertainment chairman for the evening and issued about fifty invitations to state medical society officers, councillors and committeemen to be the guests of his county society on that occasion. The attendance was large in spite of the blizzard.

The meeting opened with a cocktail hour at 5:30 on the mezzanine floor of the hotel, after which dinner was served in the main dining room of the hotel. Following the dinner the meeting was opened by Dr. Charles Dengler, president of the Jackson County Medical Society, who made an address of welcome and then turned the meeting over to Dr. Riley, who explained the general purpose of the meeting. The first guest speaker was Dr. F. A. Baker, Pontiac, member of the Economics Committee, who made a few appropriate remarks and concluded them with his famous story of Joe and Pete and the Mayor of Montreal.

Following the custom of many luncheon clubs, each person present rose and introduced himself and the guests added the name of their home city and the position they held with the state society. Dr. J. E. Ludwick of Jackson gave a résumé of the method of handling indigent venereal disease work in Jackson. He was followed by Dr. H. A. Brown, president of the Jackson Academy of Medicine and Dentistry, who explained the Jackson County set-up for indigent city and county work. This latter plan includes only the hospitalization of adults.

The next speaker, Dr. A. G. Sheets, Eaton Rapids, delegate from Eaton County, outlined the work in his county with the supervisors and expressed the pleasure of his group in being made a member of the second district. He was followed by Dr. Henry Perry, Newberry, president-elect of the Michigan State Medical Society, whose theme was the importance of belonging to the state society and being interested in medical politics. He gave a brief summary of the recent advances made by the council in the crippled children problem. His statements in that connection are reserved for other sources of information to make public as they see fit.

Dr. J. Milton Robb, Detroit, past president of the state society, was then introduced and made a few remarks on the value and limitations of the social worker and the fact that medical parasites are becoming rarer every day with the new enthusiasm of the doctors in this state. Dr. Henry Luce, Detroit, past speaker of the house of delegates, spoke in glowing terms of the work of the delegates and was presented with a floral piece by Dr. J. J. O'Meara, who had just purloined it from its receptacle in the lobby.

The entertainment chairman was pleased with the next speaker, Dr. Frank E. Reeder of Flint, his immediate chief, who somehow had arranged to have the golf trophy won by Dr. Riley last summer resurrected from its hiding place so that he could have the honor of presenting it to Dr. Riley. His twenty-six years of practice made it appropriate for Dr. Reeder to introduce three Jackson men at his table: Drs. Roberts, Lathrop and Glover, who had each been in the harness fifty years. His "blue ribbon" story was the prize of the evening. He closed his remarks with a tribute to Dr. Luce and a compliment to the Jackson group in being the first county society to have a state society night.

All those present were asked by Dr. O'Meara to stand for one minute in memory of Mr. George Campbell, a salesman of medical supplies in the state for many years and the donor of the golf trophy, whose death occurred about three months ago.

The next speaker was Dr. Grover Penberthy, Detroit, president of the Michigan State Medical Society, who covered the subject of the future of the state society. In doing so he complimented Drs. Christian, Bradley, and others for their work of the past year which has laid the foundation for the plans of 1936 and years to come. He touched briefly on the different types of committees and the work they do in organized medicine in this state.

Dr. Henry Cook, Flint, chairman of the Council, gave a summary of the work of the Council in the past year and urged local units to become more active, especially in the development of teachers in the home society and the keeping intact of the personal relationship between the doctor and his patient. Brief remarks were made by Dr. T. K. Gruber, Detroit, president of the Wayne Medical Society, and Dr. Paul Urmston, the councillor from Bay City.

Dr. Riley then introduced the new executive secretary, "Bill" Burns, who is making 2020 Olds Tower, Lansing, an address that will long be remembered in the minds of state legislators at Lansing. Bill first announced a golf tournament for next fall. He stated that there are 5,500 doctors in the state, of whom at least 4,500 should be members of the state society, which, with the 3,700 who now belong, makes a total of 800 who should return to membership this year. The state society has fourteen committees and ten sub-committees. In the new set-up for the crippled children work there are only five county societies that have not yet organized for this work. In the eighty-three counties in Michigan there are eighty-eight probate judges most of whom have been contacted in this work and their own association has promised to bring the recalcitrant members into line at once. He paid a great tribute to Judge MacAvinchey for the wholehearted manner in which he has approached the problem as a member of the Committee of Nine.

Four other guests were introduced: Dr. C. T. Ekelund of Pontiac, medical secretary of the Michigan State Medical Society; Dr. L. F. Foster, of Bay City, chairman of the Public Relations Committee, who has visited practically every county in the state within the last month, carrying the message of his committee; Dr. L. G. Christian of Lansing, member of the Legislative Committee and introduced as the representative of Ingham County; and Dr. J. E. McIntyre of Lansing, councillor of the second district, who urged the adoption of a basic science law which would automatically take care of the cults. He discussed the recent action of the lower court in Jackson in failing to convict a healer who, through a local error, was tried on the basis of not reporting a communicable disease rather than on the practicing of medicine without a license.

Dr. Riley then turned the meeting back to the president, Dr. Dengler, who announced a proposed slogan for Jackson County: "The Health of the Citizens of Jackson County Is Our Business and All We Ask Is the Privilege of Minding Our Own Business." Several motions were made from the floor by the guests expressing their appreciation of the efforts of the Jackson County Medical Society toward making the evening interesting and pleasant. The meeting was then adjourned. Attendance, ninety.

Guests from out of town other than those whom it was possible to call on for remarks included the following: Drs. C. S. Tarter, Bay City; H. H.

Cummings, Ann Arbor; A. S. Brunk, Detroit; H. A. Miller, Lansing; T. K. Jones, Marshall; Karl B. Brucker, Lansing; D. V. Hargrave, Eaton Rapids; R. H. Pino, Detroit; J. H. Dempster, Detroit; Thomas Gruber, Detroit; C. R. Keyport, Grayling; H. F. Mattson, Hillsdale; L. W. Day, Jonesville; E. B. McGavran, Hillsdale; T. E. Wilensky, Eaton Rapids; F. T. Andrews, Kalamazoo, and I. W. Greene of Owosso.

DR. H. H. CUMMINGS, ASSISTANT DIRECTOR POSTGRADUATE MEDICAL EDUCATION

Dr. Howard H. Cummings of Ann Arbor has been appointed assistant director of post-graduate medical education of the medical department of the University of Michigan. Dr. Cummings will be assistant to Dr. J. D. Bruce, who is director of the department of post-graduate medical education and vice president of the University. His position is part time, and he will, therefore, continue to carry on his practice. Dr. Cummings' appointment is a popular one with the medical profession of the state. He is councillor for the 14th district, having succeeeded Dr. Bruce in that capacity. As councillor, he is chairman of the legislative committee as well as a member of the publication committee of the council of the Michigan State Medical Society.

Dr. Howard H. Cummings

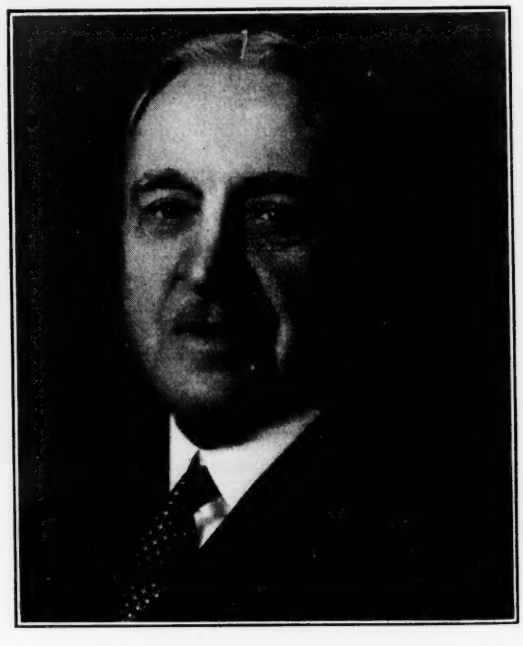
Dr. Cummings takes up the position of assistant director with a fine cultural background. He matriculated into the University of Michigan in 1905 and graduated in 1910. During his undergraduate years, he was student assistant in physiology in 1909 and student assistant in pathology in 1910. He spent the summer of 1910 in post-graduate work in obstetrics at Johns Hopkins University. The year 1910-1911, he was assistant in the department of Obstetrics and Gynecology at the University of Michigan and instructor in the same subjects from 1911 to 1913. He was executive head of the University health service from 1913 to 1917 and was associated with the department of Hygiene and Public Health in 1917-1918. He entered private practice in 1919, limiting his work to obstetrics and gynecology and, since then he has also been gynecologist and obstetrician at the St. Joseph's Mercy Hospital.

Dr. Cummings' interest in medical affairs is evidenced by the fact of his membership in various organizations. He is past president of the Washtenaw County Medical Society; a member of the American Board of Obstetrics and Gynecology; fellow of the American College of Surgeons; a member of the Michigan Trudeau Society; member of the Central Association of Gynecology and Obstetrics; in addition to his activities in connection with the council of the Michigan State Medical Society, which are well known.

The Department of Post-Graduate Medicine, as well as the Michigan State Medical Society, is to be congratulated on this appointment of Dr. Cummings.

DR. McLEAN HONORED

On the evening of January 9, the Detroit Academy of Surgery honored Dr. Angus McLean at a complimentary dinner given at the Detroit Athletic Club. The dinner marked over half a century of active surgical practice. Dr. McLean was one of the founders of the Detroit Academy of Surgery as well as its first president. Dr. Joseph Andries, president of the academy, announced that the event was a regular meeting of the academy and that he hoped the discussants for the sake of the numerous guests present would avoid the undue use of technical terms, which of course was appreciated by the many present who were unaccustomed to the scalpel as an instrument of practice. The impression of the writer (not a surgeon) was that the entire academy of surgery turned out en masse. However, our observations indicated that there was an equal number who could not qualify as surgeons. There were guests from Port Huron, St. Clair, Grayling, Owos-



Dr. Angus McLean

so, Flint, Ann Arbor, Grand Rapids, as well as many other places large and small.

The banquet brought together a large gathering of friends of Dr. McLean who had responded to do him honor. The Board of Education of which Dr. McLean has been a member for twelve years was there in full force.

The program consisted of two prepared addresses and a large number of extemporized tributes to Dr. McLean. The addresses were by two of Dr. McLean's satellites, Dr. Ray Andries and Dr. Wyman D. Barrett.

Dr. Andries read a paper illustrated by lantern slides commenting on Dr. McLean's scientific contributions to surgery. Many of the illustrations (by lantern slide) were photographs of Dr. McLean from the time he entered practice to the present day. A number of special surgical operations were both described and illustrated.

Dr. Barrett, who had been associated with Dr. McLean for twenty-one years, spoke of Dr. McLean's technic and described and illustrated instruments that had been devised by him.

Among others who were called upon for brief addresses were Drs. Grover C. Penberthy, R. C. Jamieson, James Inches, L. J. Hirschman, Mr. Frank Cody, Dr. Spain, Colonel Edwin George, Mr. Webster, Dr. Biddle, Dr. DeGurse, Dr. Bullock. Angus McLean, at the request of the evening, was called upon and spoke briefly in appreciation of the honor done him.

On the menu appeared the following important dates in Dr. McLean's active professional career:

1862	Born in St. Clair County, Michigan, April 4
1886	Graduated from the Detroit College of Medicine.
1888	Entered the office of Dr. H. O. Walker and later pursued post-graduate work in Surgery in Edinburgh
1888 to 1891	City physician.
1895 to 1901	Surgeon to Detroit Police Department.
1905 to 1913	Professor of Clinical Surgery, Detroit College Medicine.
1905 to 1913	Member of the Michigan State Board of Health. Last four years, chairman of same. President of the Wayne County Medical Society.
1917	Commissioned as Colonel and sent to France as Commanding Officer of Base Hospital 17, which he had organized before leaving.
1919	Sent to Italy as President of Medical Commission.
1919	September 15. Awarded Diploma of Honor by the French Government in testimony of his services at Dijon. The same year the French Government also recommended him for the Legion of Honor.
1920	President of the Michigan State Medical Society.
1921	PRESIDENT AND ONE OF THE FOUNDERS OF THE DETROIT ACADEMY OF SURGERY.
1921	August 21. Awarded the Distinguished Service Medal of the American War Department.
1922	Dr. McLean was Professor of Surgery up to this date when he was elected member of the Detroit Board of Education, a position he now holds for the third time.
1927	Awarded a medal and honorary degree by the University of Warsaw, Poland. This included an honorary lectureship in Military Surgery, which Colonel McLean went abroad to deliver.
1929	Was made a member of the Royal Army Medical Corps (England).

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.

DISEASES OF WOMEN. By Harry Sturgeon Crossen, Professor Emeritus of Clinical Gynecology, Washington University School of Medicine, etc., and Robert James Crossen, Instructor in Clinical Gynecology and Obstetrics, Washington University School of Medicine, etc. Eighth edition, entirely revised and reset. With 1,058 engravings, 999 pages. The C. V. Mosby Co., St. Louis, 1935.

INFANT NUTRITION. By William McKim Marriott, Professor of Pediatrics, Washington University School of Medicine. Second edition. The C. V. Mosby Co., St. Louis, 1935.

IMMUNOLOGY. By Noble Pierce Sherwood, Ph.D., M.D., Professor of Bacteriology, University of Kansas, and Pathologist of the Lawrence Memorial Hospital, Lawrence, Kansas. Illustrated, 608 pages. The C. V. Mosby Company, St. Louis, 1935.

THE PARATHYROIDS IN HEALLTH AND IN DISEASE. By David H. Shelling, M.D., The Johns Hopkins University and Hospital, Baltimore. Illustrated, 335 pages. The C. V. Mosby Company, St. Louis, 1935.

CLINICAL ATLAS OF BLOOD DISEASES. By A. Prinly, M.D., M.R.C.P., and Stanley Wyard, M.D., M.R.C.P., London, England. Third edition with 38 illustrations, 34 in color. Philadelphia: P. Blakiston's Sons and Company, Inc., 1935.

The same plates appear as in the second edition inasmuch as progress in hematology has been clinical, rather than morphological. The text, however, has undergone thorough revision, so that we have a complete compendium on blood diseases. Much information in compact form.

AIDS TO MEDICINE. By James L. Livingstone, physician to Kings College Hospital, assistant physician to the Hospital for Consumption and Diseases of the Chest, Brompton, England. Fifth edition. Price, $1.50. Baltimore: William, Wood and Company, 1935.

While these small volumes (this is one of a series) are not intended to take the place of larger works on medicine, we feel there is a place for them, since they may be conveniently slipped in one's pocket to be consulted when he is away from his medical library. The present volume on medicine has gone through five editions since it was first published in 1909. The presentation of the subject is clear and concise and thoroughly up to date.

FOR AND AGAINST DOCTORS. An anthology compiled by Robert Hutchison and G. M. Wanchope. Price $2.00. Baltimore: William Wood and Company, 1935.

"Doctors have at all times incurred the abuse of the laity, but they have also received almost extravagant praise; censure and praise being often alike ill-deserved," opens the foreword of this little book. The contents is made up of quotations about doctors and is classified as follows: Proverbs, The Ancients, Mediæval, Fifteenth to Seventeenth Centuries, The Eighteenth Century, The Moderns, Retrospect. The editors or selectors of the quotations have certainly succeeded in getting together, let us hope, all the petulant opinions that have ever been held against the medical profession of all ages. Perhaps the effect will be wholesome.

O' wad some Power the giftie gi'e us
To see oursel's as ithers see us!
It wad frae mony a blunder free us
An' foolish notion.

THE STOMACH AND DUODENUM. By George B. Eusterman, M.D., F.A.C.P., Head of Section in Division of Medicine, The Mayo Clinic, Professor of Medicine, The Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota; and Donald C. Balfour, M.B., M.D.(Tor.), LL.D., F.A.C.S., F.R.A.C.S., Head of Section in Division of Surgery, The Mayo Clinic, Professor of Surgery, The Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota; and Members of the Staff, The Mayo Clinic and The Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota. 958 pages with 436 illustrations. Philadelphia and London: W. B. Saunders Company, 1935. Cloth, $10.00 net.

This work is essentially a product of the Mayo Clinic and is based upon the wealth of experience and material afforded by the institution. There are thirteen collaborators exclusive of the chief authors, Eusterman and Balfour. Almost every condition that the stomach and duodenum may be heir to is discussed in this volume. Drs. William J. and Charles H. Mayo have contributed the foreword. The reviewer naturally emphasizes those chapters in composite work which are of a more direct appeal to him. No more competent persons than Dr. Walter C. Alvarez and Dr. B. R. Kirklin could have been found to contribute chapters on Applied Physiology of the Stomach and Duodenum (Alvarez) and Roentgenologic Diagnosis (Kirklin). The work deals with both medical and surgical aspect of the subject. The volume embodies the most recent teaching and scholarly viewpoint on the subject. The illustrations are well chosen and, without exception, picture conditions that would be difficult to describe otherwise. This work will be found invaluable not only to the general practitioner but also to the gastro-enterologist.

SURGERY: QUEEN OF THE ARTS. By William D. Haggard, M.D.; F.A.C.S., D.C.L., Nashville, Tennessee. Professor of Clinical Surgery, Vanderbilt University School of Medicine; Surgeon to Vanderbilt Hospital and St. Thomas Hospital; President, Southeastern Surgical Congress; former President of the American Medical Association, the American College of Surgeons, the Inter-State Postgraduate Medical Association of North America, the Southern Surgical Association, and the Tennessee Medical Association; formerly Lieutenant-Colonel, Medical Corps, U.S.A.; Consultant in Surgery, Mesves Hospital Center, A.E.F. With Foreword by William J. Mayo. 389 pages with 41 illustrations. Philadelphia and London: W. B. Saunders Company, 1935. Cloth, $5.50 net.

This volume consists of a collection of papers on various subjects; the title of the first paper is the title of the book. About half the papers deal with various surgical subjects. The others are on general topics such as the "Romance of Medicine," "The Seeds of Time," What Price Health." They constitute an interesting collection of essays for leisure reading.

REGIONAL ANATOMY ADAPTED TO DISSECTION. By J. C. Hayner, B.S., M.D., Associate Professor of Anatomy, Assistant Surgeon, Flower Hospital; Assistant Visiting Surgeon, Metropolitan Hospital, New York, N. Y. 687 pp. Baltimore: Wm. Wood & Co., 1935. $6.00.

This work is a somewhat novel approach for an anatomical text. It is probably too specialized for the introductory student, but should be of use to the more advanced medical student or practitioner desiring a small-sized reference.

Dr. Hayner's book has the regional rather than the systemic approach. It is concerned with those features of anatomy which are of clinical or surgical importance, yet it is not a surgical anatomy in the ordinary sense. It is surgical anatomy in which the surgery is omitted. Fractures, hernias and arterial anastomoses are left for the surgical texts.

The most noticeable difference between this work and other texts is the absence of illustrations, the student being referred to the standard atlases. The reader will find the work conveniently organized according to regions. Sections and paragraphs are set off by capitals or italics, and there is a fifty-page index. There are occasional tabulations which are helpful, and descriptions, which follow the conventional pattern, are concise. This conciseness, though it might lead to ambiguity for the beginning student, will be appreciated by the practitioner.

FUNDAMENTALS OF BIOCHEMISTRY IN RELATION TO HUMAN PHYSIOLOGY. By T. R. Parsons, B.Sc. (Lond.), M.A. (Cantab.) Sidney Sussex College, Cambridge. 5th ed. 453 pp. 26 figs. Baltimore: Wm. Wood & Co.; and Cambridge, Eng.: W. Heffer & Sons, Ltd., 1935. $3.00.

This is just the book for one desiring to review his biochemistry. It is readable and in places entertaining, yet it bears the stamp of authority which would be expected from the Cambridge laboratories. Parsons states that it has been his desire to have his book give less information than other works, rather than more. The reader will thus find the work not a repository of formulæ and tabulations, but a clear cut discussion of the subject. The book is to be recommended most heartily.

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